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ORIGINAL COMMUNICATIONS.

THE SUBSEQUENT HISTORY OF A CASE OF PROGRESSIVE PERNICIOUS ANÆMIA REPORTED AS CURED BY ARSENIC.

BY I. A. LOVELAND, M.D.,

President of the Connecticut River Valley Medical Association.

THIS disease is so little understood that when cases do occur it is the duty of the physician to report them. It has fallen to my lot to have charge of the following case:

The patient was a merchant, aged 54, of temperate habits, slightly inclined to corpulency. General health good, with the exception of his digestive system, which was deranged by reason of dietetic errors. Mother died of cancer at the age of 80, a sister of diabetes at the age of 20, and one brother had phthisis and died when 35. Two brothers living; also his father, at the age of 85,—all in the enjoyment of fair health. For months previous to the patient's consulting a physician it was evident to the casual observer that some constitutional disease was slowly invading his system. His complexion was becoming pale, even white. He found that his usual business fatigued him, and that his heart violently palpitated when he made any extra exertion, such as going up-stairs. His appetite was poor, and food was taken with aversion. He was often nauseated, and was inclined to somnolence to such an extent that he would drop off into a sound sleep during his leisure moments, even in business hours.

On the 21st of June, 1885, the patient placed himself under my care. At this time he complained chiefly of dyspnœa on exertion, and of being exhausted before the business of the day was completed. There was slight pain in the back. An examination of the heart showed no disease of that organ to account for the dyspnœa. A trace of albumen was found in some specimens of urine examined, in others none at all. It was pale, with a specific gravity of 1016, and slightly below the normal quantity. The liver, spleen, and all the other organs were carefully examined, but no evidence of disease was discovered; and yet the patient was daily becoming weaker and weaker. On the 15th of July, in going from his store to his house, he was attacked with syncope and fell to the ground. At the suggestion of Dr. D. Campbell, who saw the case on the 21st instant, the patient was put on the arsenical treatment. We began by giving him one one-hundredth grain of arsenious acid three times a day.

July 23, the exhaustion was so great that he was unable to rise in bed. He seemed to be bloodless,—as if he had suffered from a profuse hemorrhage. The conjunctivæ were pearly white. The mucous membranes, the tongue, lips, and gums, were blanched. The skin was of a marble whiteness, and this abnormal color was most conspicuous where the normal vascularity is the greatest, as in the hands and face. The nausea was distressing. Diarrhœa alternated with constipation. At times undigested food was passed, showing the defective state of the machinery concerned in the process of assimilation. The temperature varied from normal to 101°. The mind was less active than in health. Conversation was fatiguing, and the patient was apathetic. Sleep was broken. Such were the more prominent clinical features of the case when the disease was at its height.

The first signs of improvement took place after pursuing the arsenical treatment some ten days, and consisted in improved appetite, the cessation of the pain in the back, better sleep, and in being more cheerful and talkative. The dose of arsenious acid was now increased to one-fiftieth of a grain three times a day.

August 9, my note-book reads: Lips show some color, especially the lower; mucous membranes less pale. At the time of my visit the patient had lain recently on his left cheek, and a distinct redness could be seen. Complexion not so pallid.

August 13, was taken with fainting while changing his clothes, but recovered in a short time. The superficial veins of the foot can now be traced to the toes. On pressure of the tips of the fingers, evidence of an increased vascular supply can be seen in the pinkish color that the part assumes.

August 26, the patient's strength had so far improved that he was dressed and ate dinner with the family. Appetite good, no nausea, no pain in back. Sleeps well, and is greatly improved as far as the quantity of blood is concerned.

September 1. Rode to his store. Appetite voracious.

September 14. Complexion has lost its whiteness, and the blood apparently has a healthy corpuscular richness. There has been a progressive gain in strength. Patient rides to his store almost daily, and superintends his business.

The case was reported to this date in a paper which was read before the Connecticut River Valley Medical Association, and published in the November number of the *New England Medical Monthly*.

The patient continued to improve through November and the fore part of December. During a portion of this time he was able to spend the greater part of the day at his store. He was cheerful; all the functions seemed normally performed, and convalescence almost completely established. The latter part of December, however, the patient felt more exhausted, had difficulty of breathing on exertion, was nauseated, and the same train of symptoms which before existed again developed. All these conditions grew more severe through the winter. The dislike for food was so great that by the middle of April about all the nutriment the patient could be persuaded to take was Wells, Richardson & Co.'s Lactated Food and an occasional glass of milk or cream. But he soon tired of this, and then Murdock's Liquid Food was substituted. He took this as long as he was able to take any dietetic preparation, and some of the time it was taken with relish. By this time he was not able to sit up much, but usually remained in bed till noon, and then would lie on a lounge. Hands and feet were inclined to become cold, and it required active measures long continued to warm them. A prickling sensation troubled the patient, to relieve which electricity was used. He did not respond to it normally. By the last of the month fissures began to appear on the lips and tongue. By the middle of May the mind did not show its usual clearness. Some evenings he was restless. Towards the last of May he had slight attacks of delirium, was so profoundly exhausted that he could not move in bed, vomited occasionally. Skin pale and blanched, like a dead person's. A few attacks of subsultus came on after exertion. Constipation, with occasional colicky pains, existed. On June 2 had a slight hemorrhage from the nose, and also œdema of the feet. Two days later he became drowsy, which gradually deepened into profound coma. In this state he died at 10 A.M. on the 7th instant.

Autopsy.—The thoracic and abdominal cavities presented a state of bloodlessness such as is seen in cases where the patient has died of hemorrhage. The lungs were mottled and white. The heart was of normal size, pale and flabby, with signs of fatty degeneration. This paleness and flabbiness were especially noticeable in the internal muscular fibres. The small quantity of blood found in the cavities of this organ looked more like water than blood. An ounce, perhaps, of serum gravitated to just below the base of the right lung. The kidneys were anæmic, and the cortical and medullary portion looked so nearly alike that it was difficult to distinguish one from the other. Nothing abnormal was noted in the form, position, or size of the spleen and liver. The stomach and intestines partook of the universal anæmia, were almost white, and abnormally thin. No organic structure showed signs of serious local disease or of malignant growths, but every tissue seemed drained of its blood.

The literature of progressive pernicious anæmia is scanty. Dr. Addison was the first to clearly describe the disease. This he did under the name of "idiopathic fatty degeneration" in his lectures delivered in 1843, but which were not published till 1853. In Guy's Hospital Reports for the years 1847–48 and 1857, Dr. Wilks reported a few cases. Gusserow, in 1871, observed six cases; and, one year later, Biermer reported fifteen cases at Zurich. He was then not acquainted with the writings of his English contemporaries, and hence thought he had discovered a new disease, giving it the name by which it is now generally known. The profession is deeply indebted to Dr. Sidney Coupland, the distinguished English physician, for his collection of one hundred and ten cases, which was made in 1881. These cases comprised all that the most careful research could find up to that date. In this country, cases are of occasional occurrence; yet I am not aware that any attempt has been made to collect them.

The etiology of the disease is unusually obscure. Sir H. Marsh mentions a girl who accidentally poisoned her father, and who was so overwhelmed with grief that she took to her bed, became anæmic, and died. In another instance, a gentleman saw a child run over in the street. He was never well after that event. Progressive anæmia developed, and death soon occurred. A child died in Guy's Hospital of anæmia who had not enjoyed good health since he was attacked by a flock of sheep in a field. The loss of relatives has been assigned as a cause in several cases. The well-to-do are as liable to suffer from the disease as the hard-working and impoverished. According to Addison, the disease is more apt to develop in those predisposed to fat. Dr. Fenwick has shown that serious structural changes of the stomach sometimes occur in cases of pernicious anæmia. Whether it is the cause of the disease or simply the result of the disease is not now known. Should future investigation show that gastric disease acts as a cause of this particular form of anæmia, it would throw light on the etiology of the case which has engaged our attention. For years our patient was troubled with atonic dyspepsia,

constipation, etc. The idea has suggested itself that, nutrition being abnormally performed, the special pabulum required for healthy cytogenesis was wanting in this case, so that the red corpuscles could not develop in proper numbers. Some observers claim that the disease is more common in middle life; others assert that it is more apt to develop late in life. The truth probably consists in the fact that a sufficient number of cases have not been observed to settle this question. The sexes seem equally liable to the disease.

The course in progressive pernicious anæmia is usually steadily downward. Often the diagnosis is not made till the disease has reached its last stage, so insidiously does it come upon its victim. Patients may live years with the disease; yet it generally runs its course in from six to twelve months. A few cases of complete recovery have been reported. It is worthy of note that these cases were hospital patients, and that as soon as they had regained a fair degree of health they were discharged as cured, and most likely lost sight of. It is not known whether they had a fatal relapse like our patient or not. They simply stand in the hospital reports as cured.

Arsenic has a specific action in this disease. The dose should not be large enough to produce constitutional symptoms; only its tonic and alterative effects are desired. Other remedies are indicated in the course of the disease, but no drugs should be rashly administered. Meddlesome drugging always does harm. The diet should be nutritious, and also easy of assimilation, and the hygienic conditions of the best possible character.

GILSUM, NEW HAMPSHIRE.

ERGOT IN THE THIRD STAGE OF LABOR, AND ITS INFLUENCE IN PREVENTING SEPTICÆMIA.

BY V. M. REICHARD, M.D.

THE text-books, as a rule, say that ergot may be given in labor previous to the birth of the child, though all advise certain precautions in its use. It were better, however, to adopt the rule never to give ergot in the second stage of labor. The numerous and grave complications which may arise in any case at any moment forbid the employment of a drug which may carry out of the accoucheur's hands the power to control the action of the womb. A man may—and such has been the case—use ergot regularly for quite a number of years with no serious results, and at last rupture a womb. Such a result may occur in any case; but how much more readily when the womb has been ergotized! In a recent case of which the writer knows, the woman had borne quite a number of children with no particular trouble. Ergot was given, and as a result the woman is dead and the child unborn! Such is the record.

By the pressure of the almost tetanically contracting uterus the child may be still-born and all efforts at resuscitation fail. Only a dead baby! and yet Mrs. Reybold was submitted to the perils of Cæsarean section two successive times to save the lives of babes unborn. To deliver a woman who is subject to uterine inertia is sufficiently easy without ergot. Its use in the second stage of labor should be abandoned entirely. Its risks, as compared with those of other procedures, are too great.

In the third stage, however, and in the post-placental period, it is an agent of the greatest utility. Those authors who are most chary about giving ergot advise its use when the head is about passing the vulva. This, however, may cause trouble. With an adherent placenta—and there are some men who find these cases are not extremely rare—the drug may cause such severe contraction as to interfere seriously with the operator or indeed imprison the placenta within the uterine cavity. The safest rule by far is not to give ergot until the placenta is in the vagina or escaping from the mouth of the womb. Given at this time and in full and sustained doses, too much cannot be said in its favor. It lessens or prevents after-pains; it hastens involution to a marked degree; and it reduces to a minimum the dangers of septic absorption.

In this latter direction I conceive lies its greatest usefulness. The situations most favorable for the absorption of septic organisms are the denuded placental site and the occluding thrombi in the mouths of the uterine sinuses. By securing firm contraction or hypercontraction both these dangers are met. The uterine cavity being emptied thoroughly and kept almost entirely in a state of tonic contraction, the

discharges are carried out at once, the placental site is reduced to the smallest size, and the thrombi have the serum forced out, thus diminishing their value as propagating media for septic organisms.

The facts bear out these assertions. I have found that women who are thus treated with ergot do better than those who are not. The temperature scarcely rises above the normal, and they are in better condition at the end of the lying-in period.

In a recent case in which the placenta was remarkably adherent, all judicious efforts failed to remove the entire placenta. The injury to the uterine surface by prolonging further the efforts at removal was judged to be greater than the danger of leaving behind a piece of placenta. The woman was given a drachm of ergot every four hours. In twenty-four hours the lochia were very offensive, and on the third day a goodly-sized piece of placenta was discharged in a putrid state. At no time was the woman's condition at all serious. I do not wish to be understood as saying that every effort should not be made to remove the entire placenta. But what I do say is that ergot will so seal the uterine absorbing surfaces that a putrid piece of placenta may be retained and no bad results follow. Whether it be only a coincidence or the effect of a cause, opinions may differ; but I am sure that since giving ergot to every woman immediately after the expulsion of the placenta my cases do a great deal better than before I commenced to give it.

To sum up: ergot should not be given until the placenta is under entire control; then should be given several doses in quick succession until the womb is well contracted and low down; and after this a drachm every four hours. The rapidly-repeated doses may cause vomiting, but I have never seen any bad results follow this. On the other hand, the womb seems to contract more forcibly.

FAIR PLAY, MARYLAND, July 31, 1886.

ARTIFICIAL CUCAINE. — Herr Merck, of Darmstadt, has succeeded in preparing an artificial cucaine which possesses all the properties of the natural product. Benzoic ecgonine is treated with methyl iodide and a certain quantity of methyl-alcohol at 100° Cent. Benzoic methyl-ecgonine is thus obtained, and this substance is cucaine.

THIRD STAGE OF LABOR WITH SPECIAL REFERENCE TO RETAINED PLACENTA.*

BY H. C. HENDRICK, M.D,

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IT is often the case that the skill of the physician is more severely taxed in the third than in the second stage of labor. In the treatment of the subject, this paper is not designed for an elaborate article, but only to direct attention to a few points in the management of the third stage of labor which seem to the writer to be of most practical importance, and interesting to the physician because common practice compels a degree of expertness on the part of every general practitioner. Guided by the books and journals, there is yet a wide difference in procedures among accoucheurs: for instance, Churchill tells us at the close of the second stage of labor, "the child rolled in flannel and removed, we may *proceed to apply the binder*, . . . when the patient may be allowed to rest awhile, if there be no flooding, after which, *when the uterus contracts*, gentle traction should be made by the funis to ascertain if the placenta be detached; if so, it may be removed by traction-pressure upon the uterus, etc. After the placenta has been removed, the binder may be tightened, if necessary."

Cazeaux (seventh French, fifth American edition) says, after entire separation of the after-birth, make moderate traction with a view of extracting it. As soon as any resistance is felt, pass two fingers of the other hand along the upper surface of the cord to the os uteri, directing traction at first at an angle with the vagina in line with entrance of upper strait; . . . when, however, tractions have no effect, all efforts should be suspended for the time being; and he adds, quoting Merriman, this seems all that is right to do for a full hour after the child is born, . . . and, generally speaking, we can have but little expectation that the placenta will be expelled by the natural powers after it has been retained more than an hour, and we can consider ourselves justified in interference to extract it.

Playfair makes the same quotation from Churchill concerning the binder as above

* Read before the Second Annual Meeting of the New York State Medical Association, Third District Branch, held at Binghamton, New York, June 17, 1886.

for the purpose, and we think rightly, of condemning the practice; also he condemns the means of *traction by the cord*, and proceeds to advocate the delivery of the placenta alone by *expression*, or the "Credé method." Expression of the placenta from the uterus is by a *vis a tergo*, and not by a *vis a fronte:* when once the *knack* is learned there is little difficulty to be experienced. He says, for this purpose (the patient on the left side) the fundus should be grasped in the hollow of the left hand, the ulnar edge being well pressed down behind the fundus; and *when the uterus is felt to harden*, strong and firm pressure should be made downward in the axis of the brim of the pelvis; . . . that by this mode the uterine surface of the placenta is generally expelled first, the cord being within the membranes. He adds that in nineteen cases out of twenty, and *without touching the cord*, the bugbear of retained placenta will cease to be a source of dread. I should also have quoted to his credit continued grasp of the uterus ten minutes after expulsion of placenta.

Leishman is a general advocate also of the Credé method, but admits, at times, the desirability of combined traction by the cord.

Perhaps these four authors sufficiently represent the ordinary differences in procedure as taught and practised without further quotations.

1st. Churchill, in the application of the binder before any attempt to deliver the placenta. He advocates traction after an uncertain period of repose subsequent to the bandaging and *pressure* upon the uterus (which must be an exceedingly uncertain factor while the uterine globe could hardly be distinguished under the binder, and certainly could not be *grasped*,—a practice of which, it is hoped, none of us has any experience.)

2d. Delivery by traction alone, as recommended by Cazeaux.

3d. The Credé method as described by Playfair,—by expression alone.

4th. Expression reinforced, when necessary, by traction, as by Leishman.

Cazeaux and Playfair represent the extremes in modes of rendering aid.

There is tolerable agreement with those authors as to *waiting* for active uterine contractions to be resumed after close of the second stage before interfering, but with suggestions that after sufficient time has elapsed to endeavor to excite uterine contractions by friction; yet what may be sufficient time is left quite uncertain, while that delivery of placenta is usually effected in from fifteen to twenty minutes to an hour and a half. *Casual* writers vary very much in their ideas as to proper time of waiting, many of late advocating efforts towards immediate delivery.

As stated, when assistance is rendered, Cazeaux and Playfair represent opposite extremes of modes of action. The adage that the "truth usually lies between the two extremes" is not far amiss here.

We wish to give our experience, which has been that of the ordinary village and country practitioner, with an obstetric business equal to the average for one-third of a century; and during the past one-quarter of a century we do not recall a case, in our own practice, of the third stage of labor, at full term, exceeding twenty minutes,—unless the time was necessarily consumed in some extra care for the child,—and *never* a case of fatal hemorrhage: generally the time occupied from birth of the child to delivery of the placenta has been within ten minutes.

Our custom has been to proceed, without essential delay, by expression, with gentle, guiding traction. Quoting again Playfair, in his advocacy of the Credé method,—"that in nineteen cases out of twenty, *without touching the cord*, the bugbear of retained placenta will cease to be a source of dread."

We will add that the same will be true in ninety-nine cases out of the one hundred—and many times better still—by what we may call the Credé and Cazeaux methods combined, which we have essentially practised for many years. We will give the procedure in detail. We prefer to have the placental end of the cut cord ligated, to retain all the blood, and which may aid in the separation of the placenta. Immediately after tying and severing the cord and due attention to the child, with the woman lying upon her back, wind the cord about one hand and third and fourth fingers,—or fingers alone, if the cord be very short,—until the hand is brought in close contact with the vulva; the first and second fingers are carried along the upper surface of the cord to the placenta or os uteri, thereby one hand serving all the purposes of two, as illustrated in the

traction method of Cazeaux; the other hand over the uterine tumor, its ulnar side deflected, with the fingers carried as well back and around the uterus as possible, while the thumb and thenar eminence serve to antagonize and secure the most efficient possible and uniform grasp of the tumor.

By this time, usually, the womb is ready to respond; and when it responds the grasp is tightened, with a pressure bearing the uterus in the direction of the axis of the superior strait, meanwhile giving direction and slight traction by the cord. At the same time the *patient* is directed to "bear down," or, what is better, to place the palm of her hand tightly over the mouth and blow against it with all her might, and with it is sure to come the straining effort; and here let it be said and emphasized that pressure by inflation of the lungs—forced inflation—is worth more as an adjuvant expulsive force than all others combined. The leading feature of all, however, is the peculiar, expressive grasp of the uterine tumor, which perhaps cannot be fully told, but must be comprehended by the physician himself,—a sort of tactile sense that assures him he is aiding the uterus in its contraction and expulsion of its contents,—a sort of peristaltic squeeze, the position of hand aiding both in excitement and direct expulsion. Usually the work is completed with the first uterine pain, which is greatly encouraged and prolonged by the blowing efforts of the patient. Labor is over and the "bugbear of retention" gone by; but the grasp of the uterus, to prevent hemorrhage, is *still maintained*, without interruption, for some minutes,—longer or shorter, according to the tone of contraction; and the dose of ergot at this time is a source of safety. Generally, I would not rely upon it as an aid in the third stage of labor; nor do I give the full dose in the close of the second stage to secure contraction of the womb, as is the custom of some, unless measurably sure of completing the third stage ahead of its specific effect, lest it should bring on spasmodic contraction of the womb, which is one of the fruitful sources of retention of placenta.

One thing should have been mentioned, that is respecting the varied positions of the placenta assumed in the different modes of delivery. In the traction method the root of the cord and fœtal surface appear first; by expression alone generally the maternal surface is expelled first; in natural or unaided expulsion it usually descends by one edge, occupying less space in the os uteri and less room laterally in the vagina. The latter or natural position of the placenta in its descent is quite generally maintained, and nearly always when *well-balanced* aid by expression and traction is combined. Its naturalness recommends it; its success is its advocate.

If with well-directed efforts, by whatever method, the after-birth is not delivered, when shall we call it retained placenta? and what shall be done? Authors seem to make the time from half an hour to an hour and a half. We believe the latter time long enough to wait. Our experience is confined only to a few cases when called in consultation when more than this time, by force of circumstances, had elapsed; and artificial delivery, either with or without the use of an anæsthetic, was proceeded with at once with successful terminations,—one of these a cross spasmodic contraction of the whole uterus.

We believe there is nothing gained by delay, as has been done for days and weeks, but much lost. The adhesions seldom diminish. The patient, until the secundines are delivered, cannot repose; she is in a constant state of anxiety; there can be no real advance in recovery. The physician must hold other practice in abeyance to this case; he is harassed by day and by night by an impending danger from hemorrhage or septicæmia or both. There seems to be little prospect of gain by waiting. The uterus is in its nearest physiological condition at the time of the birth of the child; its inherent contractility of tissue is then alive to every exciting cause. If there be inertia present, the necessary manipulations will excite and draw the forces of the system to the part and overcome it, while the longer the delay the more tolerant is the womb to the presence of a foreign body: so to speak, it accepts its partial relief by the birth of the child from overdistention with satisfaction, and rests itself, unwilling to be disturbed.

We do not intend to pursue the subject of procedures in retained placenta, at term, in this paper to any extent. You may criticise the writer without an ex-

tended experience for presenting it, which is just the reason (want of experience) why it is presented. If any one with an extended personal knowledge and practice in cases of retained placenta can point out a better way than to avoid having them, it will be interesting information.

But there is another class of cases of retained placenta, a class of which doubtless we all have had more experience and annoyance than desired, and which might more properly come under another title,—*treatment of abortion*,—which we choose to bring under consideration at this time. Unfortunately, the rules for securing the expulsion of the placenta at full term or period of viability do not come materially to our aid here.

It is known that in abortion prior to the close of the second month of gestation the fœtus and secundines are usually expelled together, and if not, the latter are so small as ordinarily not to be a source of much danger even if not interfered with, but subsequent to that time until viability is a period causing the physician a deal of trouble. The placenta compared with the fœtus is proportionally of large size and of close attachment to the uterus, and inclined to adhere, as naïvely expressed by one of our patrons in a retention case of his wife: "I tell you, doctor, the trouble is, the thing isn't *ripe* yet."

It is rather the rule than otherwise, at this period, that cases are watched and time given them, but both patient and physician are filled with anxiety. There are oft-recurring and dangerous hemorrhages. There are bad odors, sometimes septicæmia, and always danger of it. Seldom is a case permitted to continue without some of these untoward features, while the treatment is apt to be confined to such efforts to obtain the placenta as can be achieved by one or two fingers, and ergot, which seldom succeeds in either bringing away the after-birth or materially checking hemorrhage, and, so failing, further measures are confined to the use of deodorizers, antiseptics, and the tampon if compelled to it, until nature, seemingly disgusted with itself, if not with the doctor, rouses at last and expels the foul offender, or, failing, it passes away in sickening discharges, or possibly it is rarely absorbed.

The writer confesses these delays too much the habit of his own practice in earlier professional life, but of late years I rarely wait a quarter of a day, and often not an hour. Having of late years a business copartner, hence a colleague easily at hand as an aid, I now proceed at once to remove the placenta artificially. In doing so, administer an anæsthetic, carry the hand into the vagina, remove the placenta. The results have been satisfactory.

Gentlemen, the manner of a majority of these cases coming to us for aid is known too well. The result of criminal practices on the part of parents even in wedlock, or of unfortunate girls under instruction or by the hand of professed abortionists, with the advice that when in trouble call upon a good physician. We sometimes question the responsibility of the physician to respond to such cases, but often we are brought to the bedside unconscious of the nature of the case until the moment is imminent. Quicker than can the question arise the doctor's sense of duty to human life has decided his action. The question with us here is not what cases it is our duty to attend, but how to do our duty well.

In the résumé of our subject concerning the third stage of labor, we would recommend ordinarily (1) that efforts to deliver the placenta should be made within the first ten minutes following the close of the second stage, believing the vigorous uterus more responsive then than at a later period.

2d. That the application of the binder prior to the delivery of the placenta, except in inertia of the womb, and delay when the accoucheur could not remain by the side of his patient, is not only useless, but a hinderance.

3d. That neither mode, of traction alone or expression alone, is the most efficient or desirable means of aiding in the delivery of the after-birth, but if either mode alone is to be adhered to, that of expression has the advantage over traction in being the more efficient in completing this stage of labor, and also in preventing hemorrhage.

4th. That the best method known is the proper combination of the two methods (traction and compression) combined, keeping in remembrance that there is a vast difference between pressing the uterus and compressing or grasping.

5th. Never neglect maintaining the firm grasp of the uterus for a period of some minutes following the descent of the placenta.

6th. That the best treatment of retained placenta is to not have it,—but, having it, to proceed with artificial delivery as soon as practicable; better use the most efficient means that can be deemed judicious than to leave the patient with the greater risks of hemorrhage, and a subject of adynamic and ataxic fever.

7th. The best treatment of retained placenta in abortion is to "go for it" as promptly as possible.

DISCUSSION.

Dr. C. W. BROWN: I have been much interested in the doctor's paper, and will take up but a very short time. I agree with his methods recommended for the delivery of the placenta, mine being about the same, with an exception that I will mention. As regards the time, I usually, as soon as the child is taken care of, proceed to deliver the placenta without regard to time. I place the left hand over the fundus of the uterus, grasping it as has been described, making a gentle kneading motion, and pressing as much as I am able to on the fundus of the womb. Instead of grasping the cord, my custom has been to follow up the cord, using it as a guide to the nearest edge of the placenta, and then to gradually work under the edge of it to excite contraction of the womb. I wait a reasonable length of time for the natural uterine contraction, and then, when that occurs, use the pressure on the outside and the fingers near the nearest edge of the placenta, and as the womb contracts and the placenta begins to come down I roll it on itself, so that it comes edgewise. Instead of pulling at the centre on the cord, like an umbrella towards the wind, I bring it down rolled up, without reference to the position of the cord. I believe that this is an important thing, and my experience has been that I have had no trouble whatever in delivering the placenta in a large number of cases.

Dr. ELDER: I have thought of the matter of delivering the placenta, and I have never had any trouble by retained placenta. There is one thing I have never done: used a forcible inspiration to fill the lungs with air. But I have tried to use forcible pressure. As to winding the cord about the hand and following it up, I have found it to result very satisfactorily.

Dr. JEWETT: What has been said is so nearly sound, that retraction would be out of place. I hardly agree with placing a ligature upon the placental extremity of the cord. It would seem to me that it would prevent the placenta from disgorging; it is more bulky and difficult to remove. It seems to me that there is always a great advantage to allow the blood to escape, all that possibly could, from the placenta; you have less to remove, and I think it passes easier. I have never, except in a case where I knew there was a second child, applied a ligature to the placental extremity of the cord.

Dr. JOHNSON: In addition to the method of removing the placenta in what is called "unbuttoning the placenta," I always about at the end of twenty minutes before the birth of the child, as near as my experience would allow me to guess at it, administered a dose of ergot to secure the uterine contraction and avoid uterine inertia. I think I have helped the patients in that way and promoted the third stage of labor. I do not know whether it is customary with others or not, but that has been my custom almost invariably. And in my experience of twenty-five or thirty years I have never had a case of retained placenta where it has been retained over twenty minutes or half an hour.

Dr. HENDRICK: I deem it perfectly safe always to tie the cord, and sometimes an advantage. Usually it makes no difference. More generally the placenta is detached in the last effort of the uterus, and lies in the uterus; and, if so, disgorgement has already taken place; if not, the tying of the placental end of the cord serves to retain the blood, it is neater so far as the bed is concerned; and it is an acknowledged mode of aiding in the seperation of the uterus if there is anything like adhesion; and that is the reason why I would do it. As to the giving of ergot twenty minutes before the expiration of labor and the birth of the child, I would not do it. I would be afraid of retained placenta, if given so early as that. Twenty minutes before the expulsion of the child is a very uncertain period. There may be many long weary hours before the child is born. That sudden action of the uterus is apt to throw it into a spasmodic contraction on the whole body, or an unequal contraction, which is one of the means of causing retained placenta.

REPORT ON OPHTHALMOLOGY.

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EXPERIMENTAL RESEARCHES WITH COCAINE.

WÜRDINGEN has made investigations as to effects of cocaine upon the eye, with the following results:

1. With reference to the corneal changes after cocaine-instillation noted by A. Graefe, and supposed by him to be an epithelial defect. The observation has been repeatedly made by others, and Würdingen has studied the corneal changes on

rabbits, dogs, and guinea-pigs. Several drops of five-per-cent. solution of cocaine were dropped into each eye. The one eye was kept open, the other closed. In three or four minutes the first symptom of corneal change was observed, and in about twenty-five minutes the whole superficial surface of the cornea was uneven and of a bluish tint. The surface was not defective, as the normal corneal reflex was preserved and no loss of epithelium could be detected. When, under these conditions, a drop of the cocaine-solution was allowed to fall on the cornea, it flowed over it like water over a greased surface. In the course of an hour the clouding had become so great that the iris could not be recognized. This appearance took place in the eye in which the lids were kept open. In the closed eye the cornea remained perfectly normal, showing that the closure of the lids exerted an important influence.

The repeated instillation of distilled water, as likewise the tears, seemed to prevent the extension of the corneal cloud without clearing up the tissues already affected. It seems that the corneal change is a sort of drying process of the superficies of the cornea, resulting from the conjunctival anæmia. To determine whether there was deficiency of lymph in the corneal parenchyma, the fluorescent solution of Pflüger was used. The solution was dropped in one eye which had been cocainized and in the other which was free from cocaine. In the non-cocainized eye a very slight and uniform fluorescence was observed in the anterior layers of the cornea. In the cocainized eye the coloring took place in spots which coalesced, the parenchyma of the cornea being colored. Similar results were attained with methylene blue. In another experiment the corneal epithelium was scratched away and the methylene blue employed. In the non-cocainized eye only the point scratched was colored, while in the cocainized eye almost the whole parenchyma of the cornea was deeply tinted. This the author thinks indicates a deficiency of lymph (*lymph-armuth*) in the corneal parenchyma from the action of the cocaine.

The microscopic examination of cocainized corneas shows that shortly after the instillation the epithelium is not changed, although the cornea to the unaided eye is uneven. Later on the epithelium is pathologically changed, and a partial casting off of the cells may occur. It is worthy of note that the same corneal changes occur when the cocaine is subcutaneously injected instead of being instilled into the eye.

Finally, the author shows that weak corrosive-sublimate solutions, borax and boracic acid and salt solutions, which have no effect on a non-cocainized eye, if dropped into a cocainized eye induce more or less intense clouding of the corneal parenchyma, which recall the streaked keratitis sometimes seen after extraction. —*Klinische Monatsblätter*, April, 1886.

ARTERITIS SYPHILITICA RETINALIS.

Haub describes the following case. Retina of one eye clouded, in its temporal half thickly strewn with hemorrhages. Here and there in this region fine white lines were observed, corresponding to the branches of an artery in the wall of which numerous shining white spots were observed. In places the spots had united, causing the vessel to appear entirely white. Complete occlusion of the vessels seemed to occur only in the arterial branches, and in the part of the retina where this occurred the hemorrhages above mentioned were seen, and were suggestive of retinal infarction.—*Centralblatt*, April, 1886.

EYE-SYMPTOMS IN ACUTE MYELITIS.

Knapp reports the following case. A man, æt. 32, apparently healthy, with history of syphilitic infection eight years previously, applied for treatment for amaurosis of gradual approach and which appeared simultaneously with an ascending bodily paresis commencing in the toes. On the fifteenth day of the attack a nuclear paralysis of the eye-muscles appeared, and on the seventeenth day bulbar paralysis, of which the patient died on the twenty-first day. Large doses of mercury and potassium iodide had no effect on the disease. The autopsy showed distinct hyperæmia of the meninges of the cord; copious discharge of turbid fluid on making incision; dorsal and lumbar sections of the cord softened; the cervical of normal consistence, but changed in color; subarachnoid fluid of the brain increased in quantity, and the pia mater of the base hyperæmic. The chiasm, optic tract, and nerve seemed swollen, soft, reddish gray. The microscope showed almost everywhere hyaline thickening of the intima of the

arteries with narrowed calibre; while the veins were distended and filled with blood. —*Archives of Ophthal.*, March, 1886.

CHANGES IN THE EYE IN SEPSIS.

Burgen, in a series of cases of puerperal fever, found without exception changes in the fundus of the eye. The following are some of the conclusions.

1. Retinitis septica appears both in the phlebitic and in the lymphangitic form of puerperal fever. Similar appearances are observed in connection with nephritis, diabetes, leucæmia: hence this form of retinitis cannot be considered an essential symptom of puerperal fever.

2. In panophthalmitis we have another affection of the eye which may occur in connection with puerperal fever. We may distinguish two different classes of cases.

(*a*) Cases in which the starting-point is suppurative choroiditis. This, if not of traumatic origin, is always indicative of septic disease, and in many cases of ulcerative endocarditis.

(*b*) Cases in which the retina is the starting-point, the choroid being secondarily involved. This starts as an embolic inflammation of the retina, leads to suppuration of the latter, and secondarily involves the vitreous and choroid. It indicates always sepsis, and perhaps without exception ulcerative endocarditis.—*Archives of Ophthal.*, March, 1886.

TENOTOMY IN MUSCULAR INSUFFICIENCY.

The following is taken from the report of the French Ophthalmological Society. Landolt asserted that the effect of tenotomy depends upon the amount of incision in the conjunctiva and of separation of the tissues attached to the muscle. In performing this operation, he made a horizontal incision in the conjunctiva about at the point of insertion, passed one blade of the scissors underneath the tendon, and thus separated the muscle from the sclera without the aid of a hook. Javal remarked that in divergent squint, when the diverging eye was amblyopic, it was better not to aim at a momentary complete reduction of the squint by the operation, but to leave some convergence, because later a certain amount of divergence would ensue. When both eyes possess good vision, the binocular visual act aids powerfully the result of the operation. Abadie did not think Landolt's method advantageous; it was much better by a vertical cut in the conjunctiva to expose the tendon of the muscle. In many myopes the tenotomy of the externus seemed to have a favorable effect upon the progressive character of the disease and the intra-ocular changes. Javal contended against the occurrence of insufficiency. When the refraction error was corrected the insufficiency vanished.—*Centralblatt f. Augenheilk.*

EYE-BALL TRANSPLANTATION.

The attempt of Chirbret last year to introduce the eye of a rabbit into a human orbit and obtain union between the rabbit sclera and the human conjunctiva is one which has excited interest in the profession and the community at large. The following experience of Pierd'houy is of value in connection with the subject. The patient, aged 25, had lost the right eye from variolar keratitis. Enucleation was deemed necessary, owing to the irritable state of the other eye, and was performed without anæsthesia. The four eye-muscles (recti?) were each secured by a suture, likewise the stump of the optic nerve, and these appropriately secured to the eye of a rabbit which had been introduced into the socket. The eye was bandaged for three days, and at the end of that time examined. The cornea was perfectly clear at this time, and slightly sensitive to touch. On the sixth day the cornea began to cloud; on the ninth day there was a central ulceration; on the eleventh day, corneal perforation and prolapse of the iris; on the fifteenth, escape of the lens and loss of vitreous. The collapsed ball, however, remained attached to the conjunctiva of the patient, forming a movable stump for an artificial. This was the result between two and three months after the operation.—*Klinische Monatsblätter*, April, 1886.

[There seem to be indications that the above operation is being repeated more or less extensively. It is unwise, perhaps, to say that the results aimed at in the operation are unattainable, but it is probable that the time and thought which already have been expended on this subject would have been much better employed in the endeavor to elucidate some of the many obscure questions which confront the oculist in connection with ordinary diseases of the eye. It is probably a fact that the reports of operations which belong in the same category as this of Chirbret's exhibit a

strong bias towards bringing forward the most favorable aspects of the results, and such results are to be received with caution. The case recorded above seems to be fairly stated. A point worthy of note is that at the end of three days the cornea was perfectly clear and slightly sensitive to touch. It is conceivable to the reviewer that such might be the case, and, if so, it may have an important practical bearing. If the above observation be correct, it tends to show that a transplanted eye may receive nutriment from the vessel of scleral, conjunctival, and episcleral tissue, and hence we have a practical suggestion for the treatment of corneal staphyloma, etc. But when we consider the manner in which the posterior segment of the ball—viz., that enclosing the vitreous—receives its nutriment, *i.e.*, by single vessels which perforate the sclera, it seems impossible that by any fortuitous combination of circumstances a transplanted eyeball could live, even if placed never so carefully in its new position.—H.]

THE OCULO-PUPILLARY CENTRES.

Katschanowski has placed on record the results of a series of experiments carried on in the pathological laboratory of the University of Vienna, with reference to the position of the centres governing the pupil-diameter. After a résumé of what is known with regard to this subject, including a reference to the discovery of the cortex centres by Fritsch and Hitzig in 1870, and the point located later by Ferrier on the anterior convolution of the gyrus sigmoideus, Katschanowski describes his own experiments. These were performed on morphinized dogs: the skull-cap was extensively removed, the motor cortical areas examined, and then the lateral ventricle opened to get at the basal ganglia. The principal results are as follows. In the anterior section of the anterior convolution of the cortex is a centre which, when irritated, gives rise to dilatation of the pupils,—*i.e.*, if either centre be irritated both pupils dilate. The same thing resulted from irritation of the head of the corpus striatum. Section of the vago-sympathetic in the cervical region (the vagus and sympathetic in the dog run in the same sheath) prevented the pupil-dilatation from the above-mentioned irritation on the same side; section of the oblongata prevented the dilatation on both sides; therefore the irritation of the motor centres which dilates the pupils travels *via* the medulla oblongata. Irritation of one of the posterior quadrigeminal tubercles produces pupil-dilatation in each eye; this also occurs *via* the medulla, as experiment shows. The pupil-centres of the cortex and corpus striatum are, however, independent of the posterior quadrigeminal tubercles, as the latter can be destroyed without impairing the function of the former.—*Klinische Monatsblätter*, April, 1886.

EFFECT OF LIGHT ON THE RETINAL ELEMENTS.

The interesting experiments of Engelmann with reference to the effect of light on the retinal cones have been already given in this journal. Gradenigo has reported a somewhat analogous effect with reference to retinal rods. The experiments were performed on frogs. The rods as well as the cones are connected with the granules of the outer granular layer, under the influence of light. Gradenigo reports that the filaments which unite the granules with the cones become shorter and thicker, while the granules, instead of remaining round, become oval. An interesting point brought out is that the temperature of the organ is a very important element in effecting these changes. Frogs were shut up for a long time in the dark and then both eyes enucleated,—the one examined in ordinary temperature and the other after having been exposed to a temperature of 30° to 35° C. In the warmed eye the same changes were observed in the retina as from the effect of light. [This seems to point out that the *heat* of the *sunlight* exercises an important influence on the retinal elements.—H.] Gradenigo thinks the above-mentioned changes may possibly, with the aid of more complete methods than are at present known, be traced into other constituents of the retina in which as yet they have not been observed.—*Klinische Monatsblätter*, March, 1886.

SCINTILLATING SCOTOMA.

Adolf Alt thus describes this condition as experienced by himself. For three weeks he had been feeling unwell, with loss of appetite and diarrhœa. One morning while riding over a snow-covered road in bright sunlight, he suddenly noticed a bright-yellow shining crescentic figure before him, apparently at a distance of five feet; it was projected from the retina a

little to the left of the fixation-point. Five minutes later, in his office, he carefully tested the condition of the eyes. The figure had become a little smaller; on the edge now appeared prismatic colors, yellow and blue predominating. The vision had fallen to $\frac{20}{50}$. The test-letters seemed to be in constant motion from right to left. He began to feel a little faint. He recovered in a few minutes through the help of a glass of wine. The crescent increased in size, became fainter, and finally vanished entirely.—*Klinische Monatsblätter*, June, 1886.

TRANSLATIONS.

Vaseline in Articles of Food.—The substitution of vaseline for butter or other fats in preparing articles of food, such as pastry, was recently condemned by the Council of Hygiene and Public Health of the Seine as a dangerous falsification. In order to obtain some light upon the effects upon the organism, and whether or not it possesses toxic effects, M. R. Dubois made some experiments upon two dogs with large doses. They were fed exclusively upon soup in which ordinary fat was replaced by vaseline. The amount consumed in ten days was four hundred grammes, which would in a man of average weight be equivalent to from sixty to one hundred grammes daily; therefore a much larger quantity than would be likely to be eaten in pastry. No marked change in the dogs was observed. Although deprived of fat and meat, their weight scarcely varied; if anything, they had gained. Their general condition was good; there was no loss of appetite, vomiting, nor diarrhœa; the fæcal discharges were semi-solid and yellowish; the rectal temperature was unchanged; thirst was not exaggerated; the urine was free from albumen and sugar; the quantity of urea, however, was very small. It should be observed that the only nitrogenized aliment which they received was the gluten of the bread, which contained a small proportion. Therefore we may conclude that the heavy petroleum products known to commerce as vaseline, in spite of the fact that they are not readily oxidized and are not saponifiable, are well tolerated by the digestive tube, and that they are without toxic effects, even in relatively large doses and when continued for some time.—*Journal d' Hygiène.*

The Function of the Prostate Gland.—In a paper read before the Berliner Medizinischen Gesellschaft, Professor Fürbringer, of Berlin, discussed some of the physiological and clinical relations of the prostate gland. Its secretion is a thin, more or less milky fluid, apparently an emulsion, though not of fat, but of granules containing lecithin or something resembling it. This secretion is an integral portion of the ejaculated seminal fluid; it gives to it its specific odor, and it contains a salt of phosphoric acid which causes the development of the so-called spermatic or prostatic crystals.

Professor Fürbringer has discovered another property of the prostatic secretion in stimulating or calling into activity the organic elements of semen; and he believes that in the vesiculæ seminales and ducts the matured spermatozoa lie in a dormant state, from which state they are aroused into active movement by coming in contact with the prostatic secretion. In cases of atony of the ducts in neurasthenia spermatorrhœa may exist, the discharge being free from admixture with prostatic fluid. The microscopic appearances are of the character above indicated, the spermatozoa being motionless or ceasing to move within a short period after ejaculation. By properly directed local and general treatment the patient may entirely regain his normal condition. This occurred in a case reported by the writer of the paper. A knowledge of this may protect from an unfavorable prognosis based upon microscopical examination alone.—*Berliner Klinische Wochenschrift*, No. 29.

Vinegar as an Antiseptic in the Treatment of Diphtheria.—Dr. Engelmann (*Centralblatt für Klin. Med.*, No. 14) uses vinegar, either the officinal dilute acetic acid or ordinary cider vinegar, diluted with an equal quantity of water as a gargle, or undiluted applied upon a brush. It is also used in spray diluted once or twice. It is antiseptic, not caustic, and has a more agreeable taste than many of the antiseptics usually employed.

PHILADELPHIA
MEDICAL TIMES.

PHILADELPHIA, SEPTEMBER 4, 1886.

EDITORIAL.

THE TREATMENT OF STERILITY IN WOMEN.

THE rational treatment of female sterility is based upon a knowledge of its causation. In anæmia, chlorosis, or scrofulosis reconstructive medication is required. Amenorrhœa, if the generative organs are normal, may yield to local stimulating applications, such as scarification of the cervix, introduction of the sound or of stem-pessaries, vaginal douches, hot foot- or sitz-baths, galvanism or faradic electricity; aided by aloes, apiol, or permanganate of potassium used internally. In the amenorrhœa of corpulent women, Kisch, Martin, and Röhrig extol the sulphate-of-soda waters, among which those of Marienbad have a high reputation. In this country the waters of Crab Orchard Springs in Kentucky,* Bedford Springs in Pennsylvania, or Ballston Spa in New York would probably be equally efficacious.

In endometritis, applications of tincture of iodine or of iodinized collodion to the internal surface of the uterus are often effective. When villous endometritis is present, or the uterus still contains remnants of a previous conception, the dull curette is indicated. In peri- or parametric exudations, hot-water vaginal douches and iodoformized tampons are useful.

Catarrhal diseases of the vagina must be treated with astringents. Kisch relates a case in which there were profuse hyperacid secretions. He directed injections of a fifteen-per-cent. solution of sugar to which one-tenth per cent. of caustic potassa had been added. In this solution the spermatozoa remain active for a long period. The woman became pregnant after using this injection for some time. Charrier found in two similar cases that the daily injection of a solution containing one part of albumen, with fifty-nine of phosphate of soda, in ten thousand of water, removed the acidity of the secretion, and the women conceived in the course of six weeks, although during four years of married life they had been sterile.

Gonorrhœa should be treated with germicide irrigations. The most effective are nitrate of silver (one to three thousand —one to two thousand), salicylate of sodium (one to twenty), corrosive sublimate (one to twenty thousand).

In atrophy of the uterus the galvanic and faradic currents may be used with some hope of benefit.

Vaginismus demands a careful consideration of each case. Recently cocaine in four-per-cent. solution painted on the vulva and vagina has been found effective. If this fail, operative measures (dilatation under anæsthesia and subsequent wearing of a plug) may be resorted to.

In cervical stenosis, dilatation with tents or incision may be employed. The former method is warmly advocated by Schultze. If rigid instruments are used, the solid round dilators of Peaslee or Hegar should be chosen. The dilating instruments which act by a separation of two or more blades are by Kisch considered inappropriate. In hypertrophy of the cervix, amputation is proper; in laceration, Emmett's operation.

Atresia of the vagina does not demand treatment in the absence or defective development of the other internal generative organs.

Displacements should be appropriately treated by manual reposition and pessaries or tampons.

The accepted opinion among physiolo-

* The Crab Orchard Salts may also be used at home, doubtless with good effect.

gists is that the most favorable time for conception is two or three days before the beginning, or five to eight days after the cessation, of the menstrual flow.

Kisch does not advise attempts at the artificial impregnation of the human female, as practised by Sims and some of his followers. He closes his very interesting monograph* with the caution to the physician not to be too ready to give either a favorable or an unfavorable prognosis. In the former case he may be mistaken and disappointment follow; in the latter he may likewise err, and his judgment will then be discredited in other things.

THE PURIFICATION OF DRINKING-WATER.

IF health under modern social surroundings were conditional upon the absolute purity of the water-supply, it would be hopelessly unattainable, since in its natural state water is always more or less contaminated with organic and inorganic impurities derived from the surrounding air and soil. *Per contra*, experience has abundantly shown that a considerable amount even of organic impurity may be present without notably affecting the health of those who use it. Chemical analysis, unfortunately, fails to discriminate between apparently harmless organisms, which are almost always present, and others of specific source the presence of which in drinking-water constitutes it an infected supply capable of originating epidemic outbreaks of disease. This was incidentally referred to in Major Smart's paper "On Wholesome Water for Cities and Towns,"† but has been more pointedly discussed in the recent paper by Dr. Formad.‡ By the use of cultures and the microscope alone are we enabled to pronounce with any degree of certainty upon the character of water, although in the presence of an epidemic of certain zymotic diseases we may have good grounds for viewing the water-supply with suspicion.

The advice is usually given under such circumstances to use only boiled water for drinking or culinary purpeses, and experience has proved the value of this expedient. But mere elevation of the temperature of water to the boiling-point is not sufficient to sterilize the contained germs, for ordinary fungus may survive it (Heisch), and the vitality of the spores of several forms of pathogenic micro-organisms were not destroyed by it in some experiments made by Cohn and Klein. Prolonged boiling, however, from ten minutes to half an hour, was found to free the fluids from them completely. The purification of water may also be accomplished by filtration through freshly-burnt wood charcoal or spongy iron (Parkes). It would be but reasonable to suppose that boiling followed by such filtration would, for all practical purposes, be deemed sufficient to purify water from an infected source.

In order to prevent subsequent contamination from the use of impure ice, the additional precaution should be taken, where the ice is not free from suspicion, of cooling it by placing ice around the water-vessel, or, where a refrigerator is convenient, keeping the carafe upon the ice instead of dropping ice into the water. We have observed these precautions in hospital and private practice in cases of typhoid fever, dysentery, and gastro-intestinal catarrh with results which have justified the slight amount of trouble they have required. In typhoid fever especially, we feel assured that the purification of the drinking-water is an important part of the dietetic treatment of the disease. In case of an outbreak of cholera we should adopt the same prophylactic measures, with confidence that they not only form a valuable

* Die Sterilität des Weibes. Vienna and Leipsic, 1886.

† See page 697, *ante*.

‡ "On Microscopic Examination of Water." Read before the Sanitary Convention held under the auspices of the State Board of Health of Pennsylvania, at Philadelphia, May 13, 1886.

adjunct to the treatment, but if generally adopted will go far towards preventing the spread of the disease.

NOTES FROM SPECIAL CORRESPONDENTS.

LONDON.

July 28, 1886.

A KEEN sense of sorrow has been excited throughout the profession by the announcement of the death of Dr. Walter Moxon, one of the physicians to Guy's Hospital, and joint author with Dr. Samuel Wilks of the well-known manual of "Pathological Anatomy." Dr. Moxon had passed a busy day, engaged in discharging the duties of his extensive private practice and at the hospital, and during the evening he acted as *viva voce* examiner at the Royal College of Physicians in London, where the final examinations for the L.R.C.P. were then in progress. From the college he proceeded to his consulting-rooms in the city, prior to returning for the night to his private residence in the suburbs. As he failed to reach home at his customary hour, a messenger was despatched in search of him soon after midnight, and about two in the morning he was found lifeless on the floor of his own consulting-room. His loss is one that will long be felt, and nowhere more than at the meetings of the medical societies, where his exceptional abilities as an eloquent, humorous, and at times caustic speaker were held in very high appreciation, while his vast learning as a physician made him one of the most eagerly anticipated participants in the discussion of obscure or difficult subjects.

In connection with this latest blow, the mind is irresistibly led to reflect on the very considerable number of losses which have been sustained within the last few years by the younger ranks of the profession,—of men just in the prime of life, with a brilliant record of work already done and giving promise of still more valuable performance in the future. How easily, alas! does one recall the names of Hilton Fagge, of Mahomed, of Francis Mason, of Royes Bell, and now of Moxon! Their death has more of pathos in its surroundings than that of the aged veterans whose burden of years precluded them from aught but the enjoyment of that repose to which their labors had entitled them. For the latter we must mourn indeed, but the poignancy of grief is tempered by the knowledge that the grave closes over them in the fulness of time; whereas there is mingled with the sorrow that is felt at the death of younger men a sense of the irretrievable loss to science and to humanity that is entailed by the sudden stoppage of the work that each had in hand, and that he alone could bring to full fruition. The mystery of life and death is impressed upon us at such a time as this with redoubled force.

Notwithstanding the exceedingly doubtful nature of its prospects in the late Parliament, the Medical Acts Amendment Bill of 1886 was finally among the few measures that passed both houses and received the royal assent previous to the dissolution in June. The new act does not present itself in any more attractive light on being more closely inspected as a statute of the realm. It is true that it adds five members to the General Medical Council as representatives of the class of general practitioners, three being allotted to England and Wales and one each to Scotland and Ireland. But what it gives with one hand it takes away with the other, for the concession of direct representation is more than counterbalanced by the undue influence over the affairs of the profession with which the Privy Council is endowed by the act. This august body is practically constituted a court of appeal from the decrees of the General Medical Council, and is empowered to insist on having its decisions carried into execution by the latter body. There are, however, two good clauses in the measure. The one enacts that no person shall henceforth be licensed to practise who has not passed a satisfactory examination in all three branches of the profession,—viz., medicine, surgery, and midwifery; and this will have the effect of compelling the King's and Queen's College of Physicians in Ireland to add to its list of subjects the surgery it has so long despised. Until within the last few months the Apothecaries' Society of London also granted its license without demanding from its candidates any knowledge of surgery, and this subject was only lately introduced in obedience to a "recommendation" of the General Medical Council. In future, anomalies of this kind will no longer exist, and each one of the sixty-and-odd British and Irish medical qualifications will indicate that their possessors have at least been examined in surgery as well as medicine and midwifery.

The second good point of the act is that it provides for the registration of foreign degrees in medicine when obtained by only qualified British subjects from a source of the *bona fides* of which the Medical Council is convinced. This is a much-needed improvement, for not a few Englishmen are proud of the degrees granted to them by first-class American and European Universities, and they have long felt it to be an unbearable grievance that they should be debarred from appending such honorable distinctions to the entry of their names in the official *Register*.

The first election of direct representatives will take place in November next, and already the air is laden with rumors of who will and who will not be candidates on the occasion.

For Ireland there can be but little doubt that Dr. A. H. Jacob, F.R.C.S.I., Secretary to the Royal College of Surgeons of Ireland, and Surgeon-Oculist to His Excellency the Lord-Lieutenant, will be the chosen candidate. During a long number of years this gentleman has identified himself with the question of medical reform, and at the last election of a representative of the college of which he is a Fellow, on the General Medical Council, he was only one vote below the successful candidate, who was seeking re-election at the expiration of his term of office. Dr. Jacob is deservedly popular with the profession in Ireland, and is especially known as one of the proprietors and Irish editor of the *Medical Press and Circular*, which mainly circulates in the sister isle.

The Royal College of Surgeons of England was recently the scene of the annual election of Fellows to fill the vacant seats in the Council of the College. The body in question consists of twenty-four members, each holding office for five years, and eligible for successive re-elections. Three members retire by rotation every year, and do not always aspire to be again returned to the Council, while other vacancies may of course arise through death or resignation from various causes. This year a fourth vacancy was created by the death of Mr. Cooper Forster, ex-president, who died early in the year. One of the retiring members also abstained from making a further appeal to the suffrages of his constituency, while the other two—Mr. Lund, of Manchester, and Mr. Berkeley Hill, of University College Hospital—asked to be once more returned to the Council. The total number of candidates for the four seats was eight,—viz., Messrs. Lund, Berkeley Hill, Reginald Harrison, Sibley, Willett, John Couper, Rouse, and Brudenell Carter, of whom the first four were duly elected in the order named.

Following this performance came the annual rearrangement of the officials of the College, and, much to the surprise of every one, Mr. Savory has been re-elected president, there being but a single occasion in the previous history of the College on which the same surgeon held the chief office two years in succession. Another departure, of even a more striking character, also has been inaugurated this year. Hitherto it has been the invariable rule for the senior of the two vice-presidents to pass on to the presidential chair, while his place has been filled by the then junior vice-president, who in his turn became the next succeeding president, a fresh junior vice being elected each year. Now, this order has been entirely changed by the election of two new vice-presidents in the persons of Sir Joseph Lister and Mr. Jonathan Hutchinson; the existing officers, Messrs. John Wood and Henry Power, being thus, as it were, cut off from their right of succession to the principal office in the College. The reasons for such radical changes are not of course made public, but it is not difficult to imagine they have some relation to the probable opening of the new Examination Hall by the Queen in the autumn.

The meeting of the British Medical Association, which commences at Brighton on August 10 next, promises to be a more than ordinarily successful gathering. The ease and rapidity with which the favorite sea-side watering-place can be reached from London will entice a goodly number of metropolitan practitioners to the annual reunion; and as an additional inducement to put in an attendance, the presence of Dr. Billings in the character of principal orator in the section of Medicine will be found irresistible by many who might otherwise not care to undergo the journey. The mention of Dr. Billings's name in this connection naturally recalls the mournful circumstance which led to his acceptance of the position he is about to fill; but it may safely be assumed that no one who listens to or reads the address that he will deliver will for a moment fail to remember the great loss sustained not only by American medicine, but by the profession throughout the world, when death deprived it of Austin Flint's living light and presence. In Dr. Billings, however, we shall have a worthy representative of all that is best and brightest in the country across the waters, and in the welcome that he will receive among us will be read an evidence of the harmonious relations that bind the profession in the two countries closely together.

Another most welcome guest, who has already felt something of the warmth of fellowship in the old country, will also lend *éclat* to the Brighton meeting,—Dr. Oliver Wendell Holmes. With what eagerness all classes of English society, in all places, have sought to do honor to the world-famous "Autocrat of the Breakfast-Table" is already known to those, his countrymen, who are privileged to call him their own. And it is needless to recount in this place how the great centres of learning—Oxford, Cambridge, Dublin, Edinburgh—have hastened to distinguish themselves by enrolling him among the noblest of their graduates. Indeed, it must be not a little embarrassing to the learned professor to reflect on the number and the variety of the multiplicity of doctorates with which he has been decorated during his residence in our midst. But better than all such nominal distinctions, and more grateful to himself assuredly, will be the recollection of the warm-hearted friendliness and true brotherly goodwill which he will bear back with him from the people of Great Britain, and which the nation he is returning to will readily interpret as an earnest of the common sentiment of this country towards that he represents.

An unusual effort was made this year to stimulate public interest in the Hospital Sun-

day Fund, and in the week preceding the collection a large number of open meetings were held, at which speeches in behalf of the object in view were made by eminent and popular speakers. The result, however, is anything but encouraging, as, in spite of all that has been done, the collection for 1886 is but a paltry five thousand pounds more than that obtained in 1885. And meanwhile the condition of several of the principal hospitals in London is wellnigh desperate. That of King's College especially is pitiable. Already a heavy debt is pressing on it, and its investments are rapidly disappearing under the drain to which its capital has had to respond in order to meet current expenses in excess of income. Special meetings have been held with a view to resuscitating it, but so far with little apparent effect. And University College Hospital is in straits only less serious. Even the great endowed institutions like Guy's and St. Thomas's are feeling the pressure of hard times, the agricultural depression having affected the former especially, a great part of its income being derived from land. St. Bartholomew's alone, perhaps, of all the metropolitan charities, can be looked upon as being "in funds;" but then it is by far the most richly endowed, and draws a large proportion of its income from ground-rents and similar certain sources of wealth. A full consideration of the existing state of affairs leads irresistibly to the conclusion that the whole system of hospital support and administration will have to be steadily and resolutely faced before very long, for events have quite sufficiently proved that the customs of the past are inadequate to the needs of the present and cannot possibly provide for the wants of the future.

The question of the direct representation of the profession on the General Medical Council is commencing to become a prominent subject for discussion. Within the last day or two a circular has been issued on behalf of Dr. J. Grey Glover, who seeks to obtain the suffrages of electors for the English division, to which, as previously stated, three members are allotted by the act. This gentleman's connection for a long number of years with the *Lancet* has afforded him exceptional opportunities of learning the difficulties and aspirations of general practitioners, and he has always shown a deep interest in their affairs. At a preliminary meeting in support of his candidature, held on the 29th instant, there were present Sir Andrew Clark, Dr. Wakley, of the *Lancet*, Mr. Malcolm Morris, Mr. Pearce Gould, and several other prominent members of the profession, all of whom are included in Dr. Glover's election committee. The name of Dr. Waters, an ex-President of the British Medical Association, has been mentioned as likely to be one of those whose candidature will receive the support of the Association. As this body numbers more than ten thousand strong, it is clear that whoever is backed by it must derive an immense advantage, the registered practitioners of England and Wales reaching a total of fourteen thousand. For Scotland and Ireland the numbers respectively are seven thousand and nine thousand.

There is little to record in the direction of scientific work, this being the "slack" season of the year, and most men being engaged in preparations for the labors of the winter, which will be inaugurated in October with the reopening of the societies. The season of conferences, however, is rapidly approaching, the Association meeting being, as a rule, the forerunner of them. It is announced today that Sir Spencer Wells will preside over the Sanitary Congress to be held at York in September.

The Bradshawe Lecture at the Royal College of Physicians will be delivered this year by Dr. Dreschfield, of Manchester, on August 18. The subject is "Diabetic Coma."

CHICAGO.

MIDSUMMER finds our professional ranks depleted: some have gone to the north lakes, others to the sea-shore, and again others beyond sea. Those remaining at home find no difficulty in caring for the sick, the health of the city having been unusually good. The temperature during the summer has been more even than that experienced for many years, and its low range has also been remarkable. Indeed, there are few places more favored in this particular than Chicago. With such conditions, our rate of mortality is below that of preceding years.

Local societies still hold meetings, but the attendance is not large. The last meeting of the Chicago Medical Society was mainly devoted to resolutions of respect in memory of Dr. R. C. Hamill, an old and highly-respected member of the profession. Dr. Hamill came to this city in 1851, and from that time has been identified with every movement where public health has been concerned. He was the leading spirit in the organization of the Sanitary Commission here, the Illinois Soldiers' Home, the Home for Incurables, and the Presbyterian Hospital. He had attained the advanced age of seventy-eight years, and was active up to the day of his death. His example had a wholesome influence upon all who either knew him or knew of him.

The Polyclinic has at last become an established fact. It was organized July 26. The present location, where its work is to be done, is obscure and considered out of the way, in the north division of the city. Going carefully over the list of professorships, we can hardly consider it strong in the sense that we would consider the Polyclinic of Philadelphia or New York. We question if it is strong enough to command a large patronage. In-

deed, it cannot be reasonably expected that practitioners seeking the best information upon special subjects would come to Chicago unless superior inducements were offered. The mere railway-fare from this point to New York could hardly become a consideration, in view of the much greater advantages at the latter place. It is not just yet clear as to where our Polyclinic is to get its clinical material. For the present, at least, the organization is without hospital facilities.

At the last annual meeting of one of our local medical societies, those present were treated to the sight of an ex-president peddling election-tickets, *à la* ward-politician. This would be styled by some as progressive, but it appears to me a misapplication of the term. The official positions in our societies should seek the men, and not the men the official positions.

We have another new medical school, the Chicago Ophthalmic College. The faculty is composed of our younger men. The object of the College is to give instruction to post-graduates, and, as the lecturers are, with one exception, teachers in the Polyclinic, this new institution may be considered as in some way a part of the latter.

Dr. Spitzka's article on Insane Hospital Supervision is likely to be productive of good results in this State. Of course there will be not a little protest; but Dr. Spitzka has taken time to fortify himself with reliable information, though it may not have been obtained through the State Board of Charities of Illinois.

The process of evolution in newspapers has resulted in the development of a large number of "police gazettes" in this city. The daily reader is now treated to a mixture of crime "illustrated" (*sic*), and "medicine" plain, without cuts. About the first of this month, one of our illustrated dailies came out with a sure cure for diphtheria. The "cure" was spirits of turpentine, and the dose prescribed by the editor was a tablespoonful for adults and a teaspoonful for children, frequently repeated. This criminal advice resulted in more than one narrow escape from death. We believe newspapers are irresponsible in such cases; and why not, when they can under the title of a daily newspaper fill their pages with what would be suppressed if published under the heading "Police Gazette"?

August 13, 1886.

PROFESSOR BREISKY, who has just been advanced to the position left vacant by the retirement of Professor Spaeth, of Vienna, from the chair of Obstetrics, is a man of broad views and strong convictions. The appointment is looked upon as a good one here, since Professor Breisky is well known and has always been popular with American students.

PROCEEDINGS OF SOCIETIES.

THE AMERICAN DERMATOLOGICAL ASSOCIATION.

THE Tenth Annual Session of the Association was held at Indian Harbor Hotel, Greenwich, Connecticut, August 25, 26, and 27.

FIRST DAY, WEDNESDAY, AUGUST 25.

Morning Session.—The meeting was called to order by the President, Dr. EDWARD WIGGLESWORTH, of Boston, who delivered the following

OPENING ADDRESS.

Gentlemen,—Just ten years ago, at Philadelphia, I had the honor of calling to order the first public meeting for the organization of this Association. Our specialty for the first time received national acknowledgment. Our guerilla warfare was over, and our subsequent record has been one of unbroken successive victories over bigotry, error, and ignorance.

But the day of paladins is past, and our ranks will admit more recruits. There are still remaining opportunities for more extended instruction of students in medical schools, while the lack of hospital facilities for the proper clinical treatment of diseases of the skin is a standing shame and disgrace to our municipal authorities, to our hospital boards, and to the medical profession itself. "As now arranged nearly everywhere among us, these institutions refuse to a large class of sick persons the benefit of hospital residence either wholly, or offer them, if received, not, we may fairly say, the best medical skill it is in their power to procure." Some progress has, however, been made. New York has now a special hospital for skin-diseases, besides two wards in the Charity Hospital, and Philadelphia has special clinics with beds at three different institutions.

That the workers are ready as soon as they shall have opportunity, is evident. Ten years ago our officially recognized representatives were four professors, five clinical professors, one instructor, and six lecturers: total, sixteen. To-day we number seventeen professors, eleven clinical professors, six instructors, and sixteen lecturers: total, fifty. Nor do I include genito-urinary surgery, which I regard as a distinct specialty from that of dermatology, which of course includes syphilis.

About twice as many cases of diseases of the skin are now annually treated by specialists as there were ten years ago.

The contributions to American dermatological literature during the past decade include the best treatises, hand-books, and atlases, the only periodicals, and some of the best monographs of the time, in the English language.

Our sole local organization, the New York Dermatological Society, is as active as ever, and the good work which it has already done is constantly increasing.

Two honorary and three active members of our original Association have passed away since its organization. Twelve active members, all living, have been added to its ranks. So much for our material progress and present prosperity.

Other objects of the foundation of our Association have been by no means neglected during the past ten years. There exist to-day a harmony and good feeling among us which, but for the personal acquaintanceship resulting from the formation of this Association, never would have existed. We have come into better accord as to the "Nature and Treatment of Skin-Diseases." Our increased membership proves that our Association is "held as a place of aspiration;" and it has consistently required "independent work in our department" as the essential preliminary step towards the acquisition of such membership. The systematic work of our standing committee upon Statistics has already furnished valuable data for comparison, as well as a series of excellent reports upon "Leprosy in America." Concerted official effort has done much and will do more to repress the rank luxuriance of growth of dermatological nomenclature and to furnish a "uniform and simple system."

While much has been accomplished, much still remains to be done. The idea of specialism, already rooted, is to be nurtured and trained in the minds of the profession and of the public, and the practical development socially of our specialty itself is to be elaborated in many minor details. The pioneer must no longer prove a martyr. A knowledge of the weaker side of human nature, useful for selfish financial ends, must no longer be allowed to usurp the province of exact scientific acquaintance with disease, inuring to the benefit of our race. The "elaborate division of labor" is "as useful and successful in a learned profession as it is in the mechanic arts," for it is merely a relative question of height of standard. Specialism substitutes quality for quantity, which substitution is the essential characteristic of the civilized man as distinguished from the savage, while the rapidity of such substitution gauges the progress of civilization itself. Medicine is merely that complex whole which results from the combination of all its component parts, and their individual advancement is the criterion of its own progress.

Science is only exact knowledge. Medicine is that knowledge specially directed to the physical welfare of mankind, and specialism is only that further subdivision rendered necessary by the very various parts composing the individual, and possibly by the extension of our opportunities for studying these parts, due to increase of mechanical means for enlargement of the fields of our hitherto unaided senses. No one can to-day "take all knowledge to be his province." Science does not culminate in a Jack-of-all-trades, least of all in one whose conscience has become anæsthetized by custom, who confounds his own limitations with the "limitations of human understanding," and his own ignorance with "the immaturity of medical therapeutics." The specialist builds his own boundary-wall, and cannot, if he would, poach upon the preserves of others. He "distinguishes what he can do from what he cannot," thus filling the old definition of the best physician. He cannot maltreat a patient, and, when compelled to confess ignorance and seek superior wisdom, charge the wronged sufferer another and still higher fee for a "consultation," which is in reality a confession. It has been sarcastically called "the sole duty nowadays of the family doctor to decide what specialist shall be summoned." It certainly is his duty, and a very important one as a man of honor, to decide whether any one, and, if so, who, can probably accomplish that wherein he admits that he himself has failed. Unfortunately, many know so little that they are even ignorant of how much is known by others; but in many respects the specialist has already raised the average standard of requirement for general practice to such an extent that much of the old routine practice of physicians who treated their patients for the very diseases for which they referred members of their own families to the specialist has now become punishable malpraxis. But the general practitioner has his revenge in opposing as unnecessary the hospital appointment and even the private practice of the very specialist to whom he himself flees as "a very present help in time of trouble."

We are told that "the human body is made up of parts and functions so thoroughly interdependent that it cannot be parcelled out into defined and isolated regions." It can and it cannot. What scientist divides a country into square miles and attempts to become thoroughly conversant with every atom existing in each of those miles? The special divisions of study are rather the flora, the fauna, the geological strata, etc., though all these may pervade identically every mile of the region. If regional surgery is possible, then specialties are certainly not contra-indicated. We hear of "appalling pathological conglomerates" due to lack of proper "general medical treatment." Not only "conglomerates" but often single lesions are very variously diagnosticated by different general physicians, and the "conglomerates" are usually merely the aggregated effects of original causes which might have been obviated by proper investigation in due season on the part of suitable specialists.

The aforetime "consulting physician" meant one who, in addition to his general acquirements, knew more about some particular thing than any one else. We may be sure that his general acquirements had to pay the penalty. To-day we honestly admit this, and, renouncing the practice obtainable by general acquirements, keep to that particular thing of which we know more than others. No one has mental ability enough at the present time to add to the greatly-extended knowledge necessary to the general physician the intensified fundamental acquaintance with detail needed by the specialist. Life is too short for the ablest intelligence to exhaust even any one specialty. The physician may, like Newton, "think the thoughts of God after him," but the thoughts of the Infinite upon the smallest molecule of matter call for more than the limits of a finite existence. The true consulting physician of to-day is the specialist, and he should therefore receive this title at the hospitals with which he is connected, while those ex-physicians, called consulting, but never consulted, should receive their true and proper title of Emeritus.

But enough of the "idea of specialism." The public will in time appreciate the absurdity of being content with inferior results in one branch of medicine, because, forsooth, there are so many others in which their medical adviser is equally or more at home. They will reason rather that he who "insists upon doing the work of ten men manifests a quality of mind which we can only call arrogance, and which challenges for his work severe criticism." Versatility will not atone for crude and imperfect work, any more than will lack of time, hurry of life, keenness of competition, or financial necessity; and it is merely brazen self-assertion which delights "not so much in doing the thing well as in showing how well he can do it."

Believing in the ultimate achievement of all possibilities and in the progress of truth, I have no doubt as to the future of specialism if we are honest and earnest. Not infinite omniscience, but infinite morality is the duty of the specialist, and this, conscientiously carried out, will blunt the sharpest dart of the hostile general practitioner. While visions of what yet remains to be accomplished might well lead us almost to despair, a mere glance at the generally prevailing ignorance on the part of both physicians and their patients shows conclusively that we and our work are imperatively demanded.

Dr. Wigglesworth next considered in detail the duties in the future of members of the Association as to the establishment of special skin wards in all general hospitals; as to a revision of the existing nomenclature and classification of skin-diseases; as to improvements in the Annual Reports of Transactions; the use of the metric or international decimal system; more extended statistics; the establishment of a permanent committee upon new remedies; the question of fees and the remuneration of physicians by others of the same profession; the desirability of a (proposed) "consistent schematic plan for the report of cases," always accompanied by a summary; and the duties of specialists as to instruction. He mentioned the establishment in New York of a society for the prevention of contagious diseases. Attention was called to the proposed union of all the special medical associations of America into a general "Congress of Physicians."

EDWARD BENNET BRONSON, M.D., of New York, presented a paper on

ERYANTHEMA SYPHILITICUM.

The purpose of the writer was to call attention to certain cutaneous eruptions of an erythematoid character occurring in connection with syphilis, and, so far as possible, to determine their etiology. In the first place, a case was reported of a syphilitic patient who developed a peculiar eruption upon the head, hands, and feet. Although the eruption presented no pronounced syphilitic characteristics, it was regarded as due to syphilis for the reason that it was shortly followed by an outbreak of well-marked specific efflorescences on various parts of the body, and, moreover, there was a transformation of the eruption upon the head into infiltrated lesions presenting a distinct syphilitic character. The eruption first appeared on the face in the form of an erythema which was covered with vesiculo-papular efflorescences. Later a similar outbreak occurred on the nape of the neck. The vesiculo-papules broke, leaving excoriated surfaces of a diphtheritic character from which there exuded an exceedingly abundant, foul-smelling discharge. Soon after, vegetating growths made their appearance, which upon the bearded parts of the face were quite exuberant and resembled condylomata acuminata. Those upon the neck formed more discrete, tuberous prominences, and had the appearance of condylomata lata; while upon the upper parts of the face the elevations were nummular, and had comparatively smooth though somewhat lobulated surfaces. After a week or two, the erythematous areas which formed the bases of the vegetating lesions became the seats of a gradually-increasing, copper-colored infiltration. The palms and corresponding surfaces of the fingers were covered with a deep red, sharply circumscribed erythema, which was followed by lamellar desquamation. A similar eruption occurred in patches upon the soles. The finger-nails were all more or less affected with onychia sicca. Upon the body and limbs several crops of well-marked syphilitic papules succeeded one another, and finally all the manifestations yielded rapidly to mercurial treatment. The preliminary

eruption in this case was characterized as an eryanthema dependent in some way upon the specific disease. Other instances of erythematoid eruptions, occurring incidentally to syphilis, were referred to as being more or less analogous to the above-cited case.

Allusion was made to the syphilitic roseola as a possible case in point; then to the preliminary erythematous eruptions observed in hereditary syphilis,—the *érythème précurseur* of the French,—and also to certain forms of coincident or preliminary erythema as described by Hebra, Neumann, Danielesen, Lipp, and Finger. Attention was next called to the syphilitic erythema nodosum of Mauriac, and three cases of this affection were reported, in one of which the erythematous eruption was apparently succeeded by a syphilitic infiltration that pursued a course similar to that of a breaking down gumma of the skin.

Finally, it was attempted to define more precisely the etiological relations of these various erythematoid eruptions occurring in connection with and probably as a consequence of syphilis. It was maintained that probably they were not equivalent in their mode of origin to the syphilodermata, but rather to certain angionomatic or neurotic affections, which they closely resembled. The true syphilodermata are always characterized by a specific infiltration, and are probably the result of a determination of the materies morbi to the surface. They are, therefore, pathognomonic of syphilis. The eryanthema syphiliticum, on the other hand, is only an indirect effect of the syphilis, the result of reflex irritation of the skin from the action of the disease upon nervous centres, and therefore not pathognomonic of syphilis. The fact that this might be followed by a true syphilitic infiltration *in situ* was regarded as analogous to the effect sometimes observed of traumatic irritation in syphilitic subjects, where local injuries became the seat of specific infiltrations.

DISCUSSION.

Dr. I. E. ATKINSON, of Baltimore: I wish to say a few words in regard to pathognomonic syphilitic eruptions. In this connection a great deal of caution must be exercised, and I think we should not dogmatize with regard to the specific lesions of syphilis. Lesions similar to those described by Dr. Bronson are not of excessive rarity in cachectic subjects and in cases of malignant syphilis, but in my experience, when specific, they have always been manifestations of late tertiary syphilis.

Dr. J. C. WHITE, of Boston: The occurrence of the forms of disease which have been described are so rare in syphilis, we know so little of the nature of erythema nodosum and its causes, and we know so little of the nature and causes of so-called erythema herpetiformis (which I think should be called erythema multiformis), that it seems to me we must have some more exact data before we can regard these affections as a necessary sequel of syphilis, and as anything more than accidental occurrences. While there is nothing *a priori* against a causal relation existing between these conditions and syphilis, such relation has not been proved. The early roseolous exanthematous condition of the skin in syphilis is of sufficiently frequent occurrence to be looked upon as a distinct feature of syphilis. This is wholly unlike the rare forms of dermatitis which have been described to-day.

Dr. F. B. GREENOUGH, of Boston: Syphilitic roseola seems to me to be decidedly distinct from other forms of congestion of the skin, especially in one point,—that is, during the subsidence of the congestion little points of distinct congestion continue for a long time. These appear to represent the follicles. The points of pigmentation are also an almost constant occurrence. This I have not seen in other forms of affection of the skin.

Dr. G. H. TILDEN, of Boston: It seems to me in the present state of our knowledge that it would be more philosophical to consider the appearances described as accidental than as dependent upon the specific disease.

Dr. I. E. ATKINSON, of Baltimore, then read a paper on

RUBELLA, OR RÖTHELN.

The paper was based upon a review of the literature of the subject and a study of the reported cases. The disease was regarded as distinct from measles and scarlet fever. The period of incubation varies between two and three weeks. In many cases there is no prodromal stage; there may, however, be prodromata for twelve or twenty-four hours; catarrhal symptoms are generally absent, but they may be present; sometimes there is congestion of the throat; swelling of the lymphatic glands is a peculiar and marked symptom; this swelling is painful, but does not pass on to suppuration. In many cases fever is absent; the eruption first appears on the forehead and face, and in the course of a few hours spreads to other parts of the body; the eruption is more or less irregular, being more intense in some situations than in others; from the beginning to the disappearance of the eruption is usually three or four days. In the greater number of cases desquamation fails to occur; complications and sequelæ are not unknown, the most common being bronchitis, pneumonia, and gastro-intestinal disorders; renal affections may follow this disease; relapses occasionally occur, but not later than the end of the second week. The prognosis is almost always favorable.

The only difficulty in diagnosis is in connection with measles, and in isolated cases a thorough consideration of all the points is essential to a correct conclusion. Very little

treatment is required, except in the presence of complications.

On account of the confusion existing as to the nomenclature of this disease, the speaker suggested that rubella be accepted as its proper title, and that it might be known in popular language as epidemic roseola.

DISCUSSION.

The PRESIDENT: Several years ago I suggested that measles be called morbilli, and rubeola or rötheln be used to signify what is termed German measles, and roseola be reserved as the title for the rose-colored spots seen in syphilis and other conditions. There does not seem to be any necessity for the introduction of a new term.

REPORT OF A CASE OF LYMPHADENOMA (MYCOSIS FONGOÏDE) AND AUTOPSY.

In the absence of the author, Dr. G. H. FOX, of New York, the following paper was read by the Secretary.

The paper described the case of Mrs. G., aged 33 years, the mother of six children. During pregnancy in the summer of 1881 she suffered with general pruritus, which passed away after confinement in October. A year later, small flattened circular tumors appeared in the axillæ and on the breast. These became moist and were accompanied with a burning sensation. The eruption disappeared from these situations and reappeared upon the back and other portions of the body. After the birth of her last child, in February, 1885, a tumor developed at the inferior angle of the left scapula; the lesions on the other parts of the body disappeared, with the exception of two spots on the finger and one on the left cheek; the tumor on the left scapula gradually softened and disappeared.

The patient was admitted to the hospital in October, 1885, and was fairly well nourished. There were at this time numerous tumors over the body, some of which were superficially ulcerated; the worst tumors were on the breast. Hypodermic injections of Fowler's solution were used without benefit; chaulmoogra oil was given in increasing doses until forty drops four times daily were taken, without causing any improvement.

The patient died in April, 1886. The microscopical examination gave the usual appearances of these growths; the internal organs were found to be normal.

DISCUSSION.

Dr. G. H. TILDEN, of Boston: One year ago I reported a case of this disease. I said then that it was not sarcomatous. Rindfleisch states that he has found a distinct micrococcus inside of the blood-vessels in this connection, and recently this has been confirmed by another observer. It looks as though what we ordinarily know as malignant lymphoma, affecting the lymphatic glands, with deposits in other parts of the body (Hodgkin's disease), is one of the infectious diseases. I should not be surprised to find that this mycosis fongoïde is a variety of the same disease, and that it is nothing but an acute infectious disease.

The next paper, entitled

A NOTE RELATIVE TO THE BULLOUS ERUPTION OCCURRING AFTER THE INGESTION OF IODINE COMPOUNDS,

by Dr. J. N. HYDE, of Chicago, was, in the absence of the author, read by the Secretary.

The first case described was that of an infant seven months of age. Six weeks before coming under observation the child had suffered from a febrile attack, the exact nature of which was not known. Three weeks later the eruption made its appearance. The lesions at first presented the appearance of chicken-pox. The child's face, the dorsal aspect of the hands and forearms, and the scalp were covered with isolated, whitish, split-pea to marble-sized, flattened, slightly umbilicated lesions resembling molluscous tumors. The contents of the lesions were inspissated, thick, and grumous, and of such consistency that they did not escape on rupture of the sac. It was learned that iodide of potassium in one-grain doses had been administered for the febrile attack. On the discontinuance of the iodide and the use of antiseptic powder, the lesions rapidly disappeared.

Case II.—A lad 15 years of age, who had recently undergone an operation for necrosis of the right femur, developed an eruption involving the entire body. There were two distinct sets of lesions. That which predominated was composed of annular circinate plaques, varying in diameter from several centimetres to half a metre. There were also here and there, particularly about the finger-ends, distinct blebs. The patient had been taking iodide of potassium in fifteen-grain doses. This was discontinued, and the eruption speedily disappeared.

There are two distinct types—the bullous and the quasi-bullous eruption—produced by the ingestion of iodide of potassium. In the first form the patients are often well advanced in years, often cachectic, and frequently affected with syphilis or other grave disease. In what may be regarded as a second subform of this exanthem, there are di- or polymorphic symptoms. Here bullæ are commingled with papules, tubercles, and other patches of disease. The speaker then described other cases of similar eruptions described by various writers, and in conclusion presented the following interrogative propositions:

1. Are there not three sub-forms of the bullous exanthems developed in certain individuals after the ingestion of iodide of potassium?

2. Is not the first and most common of these to be generally recognized in persons of advanced age and cachectic condition, the rash being then present in the form of typical bullæ?

3. Is there a second and still rarer sub-form, in which the eruption is displayed in di- or polymorphic manifestations, typical, perfect bullæ being then mingled with papules, tubercles, scarlatiniform maculations, or with other and different lesions?

4. Is there not a third and rarer sub-form, the quasi-bullous rash to be most frequently recognized on the face and dorsal aspect of the hands and forearms of infants and children, where the lesions are semi-solid, slightly umbilicated, and filled with inspissated, yellowish matter, and which may shrivel and desiccate on the suspension of the drug inducing the condition?

5. Is this last-described lesion one to be recognized solely as the result of the ingestion of iodide of potassium, never under other circumstances, and one as peculiar to the special condition it represents as is the gumma to syphilis?

DISCUSSION.

Dr. R. W. TAYLOR, of New York: While the most common eruption produced by iodide of potassium is an acneiform exanthem, yet it may cause dermatitis with multiform lesions and with bullæ, which may contain serum, pus, or even blood. I think that many of the cases of extreme dermatitis multiformis which have been described have been due to this cause.

I recently saw a peculiar form of iodine intoxication. It was in a case of gummatous infiltration of the pharynx, where iodoform had been resorted to as a local application. In the course of two hours it produced a diffuse eruption on the face, neck, and hands. On the hands it assumed an eczematous character.

Dr. J. E. GRAHAM, of Toronto: I have had one case similar to that described by Dr. Hyde. A young man 22 years of age had contracted syphilis two years previously. Noticing some pimples on his face, he received a preparation of iodide of potassium containing five grains to the dose. I saw him two days after he had begun to use this preparation. He then had a bullous eruption principally upon the face and neck. At that time I thought that it was a tertiary manifestation, and increased the dose of iodide to fifteen grains. Two days later, the eruption on the face was much increased, and, recognizing the cause of the condition, the remedy was stopped and the eruption rapidly disappeared.

Dr. I. E. ATKINSON, of Baltimore: One year ago I saw a case of what was supposed to be malignant syphilis: the patient had had syphilis and had been put on the use of iodide of potassium. The lesions continued to increase, and after the iodide had been taken for six months I saw the case. There was an enormous formation of scar-tissue over the face and neck. In addition there were bullæ and elevated infiltrated plaques. The appearances presented were unlike those produced by syphilis, and I thought that they were due to the iodide of potassium. The drug was stopped, and in six weeks the ulcerations had healed: the cicatricial tissue of course remained. I think that we cannot lay too much stress upon the dangerous conditions which may follow the administration of the iodides.

Adjourned until eight o'clock in the evening.

Evening Session.—The first paper presented was by Dr. R. W. TAYLOR, of New York, on

PRECOCIOUS GUMMATA.

After a thorough consideration of the subject, and the presentation of a number of illustrative cases, the following conclusions were presented.

1. Like the osseous affections, affections of the nervous system, and malignant syphilides in general, besides many other affections, syphilitic gummata may be precocious in appearance, occurring as early even as the second month of infection, but usually in the third or fourth month, or after that time.

2. Of the precocious gummatous syphilide or gummata, there are three quite clearly marked forms: first, the early, general, and copious form; second, the more localized form, which may invade several regions, is usually symmetrically distributed and sometimes even is confined to one region, particularly one side of the face or scalp and the roof of the mouth; third, a form in which more or less severe neuralgias precede and accompany the eruption, which in many particulars resembles simple erythema nodosum, but which in its etiology is not in any way related to this simple form of eruption, but is a direct outcome of the syphilitic diathesis.

3. That these precocious gummata partake in general of the features of those of later forms, but that they differ in the more acute invasion, in a much more rapid course, and are usually not so profound and destructive in their action as the classical eruption.

4. That of these precocious forms of gummata there are found to be two varieties, one a *non*-ulcerative or resolutive, the other ulcerative.

5. That in the treatment of these precocious gummatous syphilides a combination of mercury and iodide of potassium is much more efficacious than is mercury alone.

Dr. F. B. GREENOUGH, of Boston, then read a paper entitled

CLINICAL NOTES ON SCABIES.

The speaker said that since the establishment of the special department for skin-dis-

eases at the Boston Dispensary, thirteen years ago, he had had the opportunity of studying a large number of cases of scabies, and had been much interested by the rapid increase in the number of cases seen during the past few years. The number of cases had rapidly increased from three in 1879 to one hundred and sixty during the last year. He had during the past year also made inquiries as to the number of members of the same family of whom the patients could give an account as being similarly affected, and had records of one hundred and ten such cases, which, with six cases seen in private practice and the one hundred and sixty above reported, made a total of two hundred and seventy-six cases that had come under his cognizance during the past year. The percentage of cases of scabies had varied from three-tenths per cent. in 1876 to over thirteen per cent. during the past year. This great increase in frequency seemed to be one of the most interesting and important points brought out by his notes. During the war the disease naturally increased, and the medical officers got a knowledge of it which they carried with them into private practice after the war was over. The disease, being properly treated, became so less frequent that the new generation of physicians saw little of it, and each case not recognized proved a focus of contagion for a large circle. Four-fifths of the cases seen were between five and thirty years of age, and only four cases were over sixty years of age.

The facts which were especially noticed were the few cases in which typical burrows could be found; the great constancy of the manifestations on the penis in male subjects; the difference of the symptoms produced by scratching according to the situation of the lesion; and the success of treatment. He had used almost entirely an ointment consisting of two parts of sulphur, one of carbonate of potash, and three of petroleum ointment, simply cautioning the patients against applying it to inflamed and pustular localities. He referred to the distribution of the eruption as of importance in the diagnosis of difficult cases, and called attention to the differential diagnosis between scabies and certain other cutaneous diseases.

DISCUSSION.

Dr. A. R. ROBINSON, of New York: In some cases, where there was difficulty in the diagnosis, I have reached a positive conclusion by opening a vesicle and examining its contents under the microscope, and finding the young acari or the fæces.

Dr. L. N. DENSLOW, of St. Paul: I have had a number of cases in which no burrows could be found, but under treatment suitable for scabies they have recovered. The treatment used has been thorough scrubbing from head to foot, followed by the application of sulphur ointment. In regard to the complaint known as prairie-itch, I should, from my experience, say that it was nothing more than scabies.

Dr. E. B. BRONSON, of New York: I agree with the author of the paper as to the frequent absence of the cuniculi. In many cases I have depended largely upon the elongated character of the efflorescence in making the diagnosis. For three months I treated all cases of scabies with naphthol, using a fifty-per-cent. preparation, rubbing the body thoroughly with this once. This has produced a satisfactory result.

Dr. S. SHERWELL, of Brooklyn: I have recently seen an increased number of cases of scabies, and a large proportion of the cases has been among Scandinavians. I thought that this might be due to want of thoroughness in the cleaning of the ships in which the emigrants are brought to this country. As a prophylactic, I always direct the patient to sprinkle on the sheet of the bed a teaspoonful of the dry sulphur. This acts as a disinfectant, and is unpleasant to the acarus.

Dr. H. W. STELWAGON, of Philadelphia, then read a paper entitled

CLINICAL OBSERVATIONS REGARDING THE VALUE OF RESORCIN, ICHTHYOL, AND LANOLIN IN CUTANEOUS DISEASES.

Resorcin in Eczema.—It is rarely of benefit, but possesses some power over the itching. For this purpose a six-per-cent. ointment is useful. In greater strength it is irritating. In tinea sycosis it has proved of some value in ten- to twenty-per-cent. strength. In tinea tonsurans it is inferior to the remedies usually employed. In one case of leg-ulcer, healing took place under its use. In a second case no effect was produced. In seborrhœa and alopecia dependent upon this disease, a lotion consisting of a drachm of resorcin, one or two drachms of castor-oil, five minims of Peruvian balsam, and four ounces of alcohol, was of value. In tinea versicolor it was found less useful than a solution of hypophosphite of sodium. In psoriasis and in one case of lupus erythematosus the result was negative. In one case of superficial epithelioma a fifty-per-cent. ointment produced a good result, in a second case a fair result, and in a third the result was negative. In a case of favus, a twenty-five-per-cent. ointment used for two months produced no decided effect.

Ichthyol.—In a small proportion of cases of rosacea and acne vulgaris a ten- to twenty-per-cent. preparation was found beneficial. In eczema it was valueless, and usually irritating. In furunculus it acted with good results in three cases when applied as a twenty-per-cent. plaster. In the fourth case it had no effect. It was of service in psoriasis, and also in a case of lupus erythematosus. In favus it was used without effect.

Lanolin.—In some cases as an ointment-

base this is superior to the ordinary fats in use. Where a simple protective action is desired, it is inferior to vaseline, cold cream, or lard. In chronic cases where there is infiltration and where a degree of penetration is the object, lanolin is especially valuable. The writer stated that according to Liebreich a lanolinum purissimum was now manufactured, in which cholesterin ethers were absent. The main disadvantage of lanoline as now manufactured from sheep's wool is its strong sheepy odor. In a few acute and sub-acute cases of eczema, a lanolin, for some reason, proved irritating. As a rule, however, it is bland and unirritating.

Adjourned.

SECOND DAY, THURSDAY, AUGUST 26.

Morning Session.—The first paper, by Dr. G. H. TILDEN, of Boston, was on

TROPHONEUROSIS OF THE SKIN CAUSED BY INJURY OF THE MEDIAN NERVE.

E. F., 55 years of age, was wounded in the wrist by a circular saw, on November 10, four months before coming under observation. The wound was parallel with the limb. The wound was sewed up, and healed in about ten days. Three or four days after the infliction of the injury there was loss of the tactile sense and a feeling of numbness in the last two phalanges of the fore and middle fingers. This has continued and steadily increased. There was at first a slight feeling of numbness in the thumb, but this gradually diminished until it disappeared. Three weeks after the accident a bulla appeared upon the terminal phalanx of the middle finger. Similar lesions have developed from time to time upon the last two phalanges of the fore and middle fingers. The bullæ appear every two or three weeks, and are unaccompanied by any subjective sensation. These leave superficial excoriations which heal in the course of ten days. The skin over the affected phalanges is of a white color and of glossy texture. The growth of the nails is unaffected. There was entire loss of sensation in the skin covering the affected phalanges. The right hand is capable of exerting only one-half the power of the left, the first and second interossei muscles exhibiting the reactions of degeneration.

Six weeks' treatment with the faradic current caused decided improvement in all the symptoms. During this period only one bulla formed. He then stopped treatment and returned to work. Three weeks later all the former symptoms suddenly returned. It was proposed to the patient that an incision be made over the seat of injury, with the view of determining the exact condition, and if possible remedying it. The patient has not since been seen.

Whether the trophic nerves exist as individual and special nerve fibres, or whether the motor and sensory nerve fibres are the ones by which the nutrition of the tissues is governed, is unknown. The latter view was considered by the author as the most rational. Injury or disease of the motor or sensory nerves, as well as disease of the ganglia and central nervous system, may disturb not only motor power and sensation, but also the nutrition of the tissues. That it does so is by no means the case; but why trophic changes should take place in one instance and not in another is not clear. A number of cases have been reported showing that such changes are more apt to follow partial injury of a nerve than complete section. The changes commonly seen in these cases are the so-called glossy skin and vesicular and bullous eruptions, followed by superficial excoriations. The treatment of these cases consists in the use of electricity and the application of blisters over the seat of injury. A last resource, is to cut down upon the affected nerve and endeavor to relieve any constriction or pressure upon the nerve which may be found. If no such condition is detected, resection of a portion of the nerve might be advisable, since complete section is not apt to be followed by spontaneous trophic changes, and since it has been found by some observers that resection of a portion of the affected nerve is sometimes followed by the arrest of the trophic changes.

Dr. JAMES C. WHITE, of Boston, then read a paper on

NATIVE PLANTS INJURIOUS TO THE SKIN.

The object of the paper was to show that the number of plants growing native and cultivated in the United States which are capable of exciting some degree of dermatitis by contact is much larger than is generally supposed, and that cases of such inflammation of the skin not infrequently occur without being understood, because the patient has not been exposed to the two or three plants which alone are considered to be poisonous. He enumerated over fifty species which have irritating properties when brought in contact with the skin. With reference to rhus-poisoning, the speaker said that the rhus toxicodendron was comparatively innocuous, while the rhus venenata was the most poisonous species of this plant. The treatment is the ordinary treatment of dermatitis. There is no specific for this form of dermatitis.

The next paper, by Dr. H. O. PIFFARD, of New York, was entitled

NOTES ON DRUGS.

He referred briefly to several recently-introduced preparations.

Dr. F. B. GREENOUGH, of Boston, presented

A FEW ADDITIONAL NOTES ON PSORIASIS.

The paper was supplementary to one presented at the last annual meeting of the As-

sociation, a continuation of the tabulation of cases of psoriasis seen during the past year. The facts previously noted with reference to age, sex, the time of the first appearance of the disease, and the number of cases, had been confirmed. In addition to these statistics, the author, owing to the fact that a statement he had made at the last meeting in reference to the general health of the patients had been doubted, had attempted to obtain further testimony upon this point. He found that, as a rule, patients with psoriasis were above par in general health and strength. He had records of twenty-nine cases out of twelve hundred and twenty cases of skin-diseases, giving a ratio of cases of psoriasis of two and one-third per cent. The youngest case was nine years of age, while the oldest was fifty-seven years. The reader thought that the interesting deductions to be drawn from his cases were the facts that while nine cases showed symptoms of psoriasis under ten years of age, one was first attacked at the age of fifty-seven years; that out of twelve cases in which evidence could be obtained, four gave a decided history of the existence of disease in some member of the family, and that these cases showed such a high standard of general health. He considered this latter fact as a strong argument against the possible connection between psoriasis and syphilis. The speaker had never seen psoriasis of the hands unassociated with evidences of the disease in other parts of the body.

Dr. A. R. ROBINSON, of New York, then read a paper on

CHONDROMA OF THE UPPER LIP.

The tumor occupied the right side of the upper lip of a man thirty-six years of age. It had been growing for two years, and was one inch in length by three-fourths of an inch in diameter. It was egg-shaped, the broad end having its seat in the submucous tissue among the mucous glands. The mucous and cutaneous structures were freely movable over the tumor, which was sharply limited, somewhat encapsuled, and nourished by a small artery entering at the base. Microscopical examination showed the tumor to consist of embryonic, gland-, and connective tissue. The gland-tissue was formed of hypertrophied mucous glands and new gland-tissue. The amount of new gland-tissue could not be correctly estimated, because much that resembled gland-tissue represented an early stage in the process of cartilage-tissue formation. The connective tissue was myxomatous, fibrous, and cartilaginous. The myxomatous was present principally at the periphery, and did not represent œdematous fibrous tissue. Fibrous connective tissue was present chiefly between the islands of cartilage. The bundles were small, and the fibrils very fine and often rather indistinct in outline. There were several islands of cartilage, the largest being in the central part of the tumor. All varieties of normal cartilage were present, viz., hyaline, fibrous, and reticular, and also the variety met with in the heads of cephalopods,—namely, cartilage with ramifying or branched cells (*chondromes à cellules ramifiées*).

The cells showed great diversity of forms and sizes. The bodies of the branched cells presented a great variety of form. Some were surrounded with a capsule; but in the majority of cases this was absent or only faintly indicated. In some places the islands of cartilage had joined each other, but usually they were separated by the other constituent tissues.

The affection was considered to be very rare. It has been described by Paget under the name of "labial glandular tumors."

Dr. P. A. MORROW, of New York, read a paper on

KERATOSIS FOLLICULARIS, ASSOCIATED WITH FISSURING OF THE TONGUE AND LEUKOPLAKIA BUCCALIS.

The patient, C. O., a sailor, aged 21 years, came under observation in December, 1885. Five years previously, soon after beginning his seafaring life, he noticed a number of blackish points upon the back of the hands, some of which he squeezed out. Soon afterwards these appeared upon other parts of the body. They improved when he was on land, but were aggravated when he was at sea. The entire surface of the body, with the exception of the face, palms, and soles, was found to be the seat of the follicular disorder. The ducts of the sebaceous glands were occupied by comedo-like bodies, projecting sometimes one-fourth to one-half an inch above the surface. From many of the follicles small white hairs protruded. The comedos, when pressed out, were hard and dry. The hard portion of the comedo was continuous with an adhesive substance dipping deeply into the follicle. There was no evidence of irritative or suppurative action. They were not accompanied with itching.

The tongue was large, and rough to the touch; the surface was deeply fissured, the fissures extending to the submucous tissue. The buccal mucous membrane presented a bluish-white appearance, thickened and raised in places, forming distinct plaques, which were superficially fissured. The patient stated that the tongue had been white and a little sore ever since he could remember. The absence of irritation or marked sensitiveness of the fissured organ was quite noticeable. Examination seemed to exclude the possibility of a syphilitic origin. The speaker referred to other cases which had been reported. He objected to the term ichthyosis, since that suggests a disease of a different nature. He selected the name keratosis follicularis as

more correctly expressing the pathological condition present, as well as indicating the anatomical seat of the disorder. Drawings representing the microscopical appearances of the lesions were presented.

While in the hospital the patient improved decidedly under the use of local applications of linseed oil; but within a short time of the discontinuance of the treatment the condition became as marked as before treatment was employed.

Adjourned until evening.

Dr. J. E. GRAHAM, of Toronto, Canada, read a paper on

A CLINICAL STUDY OF SCLERODERMA.

He first related the histories of two cases of this rare disease, one of which occurred in the practice of Dr. Smith, of Seaport, Ontario, and the other was referred to him by Dr. Jenner, of Picton. The first patient, Mrs. R., 47 years of age, had previously suffered from rheumatism. The hardening of the skin began in March, 1882, and was first noticed over the back of the neck. It gradually spread so that in about ten weeks the integument over the greater part of the body was affected. The movements of the limbs, as well as those of respiration, were impeded. The internal treatment adopted was liquor ferri iodidi and liquor arsenitis. A faradized bath over the surface of the skin was used. In six weeks the skin began to grow softer, and in ten months the patient was quite well. There has been no return of the difficulty.

The second patient, Mr. H., age 37, came under observation in May, 1886. There was a history of hereditary rheumatism. The disease had commenced some months previously. The first symptoms were stiffness of the limbs, with œdema of the lower extremities. Then hardening of the skin over the hips was noticed, which gradually spread and was accompanied with pigmentation. The treatment consisted in the administration of potassium iodide at first, and latterly of salicylate of sodium. There has been some improvement under this treatment.

In his remarks in connection with the disease the speaker referred to the following points: 1, that the disease is found principally in temperate climates, and occurs in seasons when there are sudden changes in the weather; 2, that it is more closely related to rheumatism than has been supposed; 3, that although morphœa has in all probability a similar pathological origin to scleroderma, yet the clinical distinctions are so marked that, at present, it is expedient to treat it under a different name.

DISCUSSION.

Dr. L. N. DENSLOW, of St. Paul: In one case of scleroderma in which there were two large plaques on each pectoral region, benefit has followed the daily use of the constant current.

Dr. LE GRAND N. DENSLOW, of St. Paul, read a paper on

CARCINOMA CUTIS.

The patient, aged 49 years, had been an invalid for several years. He had had a severe right pleurisy, and presented the physical signs of absence of the right lung. The skin of the right chest from the second to the seventh rib, and from the posterior border of the axilla to the median line, was covered with a nodular new growth, which presented no ulceration. Around the nipple the nodular mass for an area of six square inches reached a thickness of one inch. The older portions of the growth were covered with thickened epidermis with thick brown scales. There was slight enlargement of the axillary glands. The different nodules were not movable beneath the skin, but the whole mass was free from the fascia. The mass was not painful on pressure, but was the seat of occasional neuralgic pains. The duration of the growth was seven months. The patient died four months after coming under observation.

The autopsy showed obliteration of the right lung. The left lung presented many small solid nodules. In the mesentery there was a nodule one and one-half inches long by one-half inch in diameter. The microscopic examination of these masses showed that in them all connective tissue preponderated. The growth on the skin occupied the papillæ and the deeper portions of the corium.

DISCUSSION.

Dr. I. E. ATKINSON, of Baltimore: This case suggests what has been termed lenticular cancer, in which the growth sometimes becomes perfectly continuous. These cases are exceedingly malignant. In a case of my own which presented appearances similar to that of Dr. Denslow's patient, the disease ran its course in two or three months. These cases are so malignant that it would seem that no operative procedure is justifiable.

Dr. R. W. TAYLOR, of New York: I might allude to two cases which were for a time looked upon as cases of cancer of the nipple, both in men. They eventually turned out to be cases of hard chancre; but in one case the induration was so great that carcinoma was strongly suspected.

Dr. I. E. ATKINSON, of Baltimore, read a paper on

SCARLET FEVER AND SCARLATINIFORM ERUPTIONS FOLLOWING INJURIES AND OPERATIONS.

The speaker first referred to the literature of the subject, referring to the cases on rec-

ord. In many of these cases it was held that the affection had been a true scarlatina. In other cases the scarlatiniform rash was of a septic origin. Various drugs which are frequently prescribed in traumatic cases will produce such eruptions, special reference being made to the cinchona alkaloids. The eruptions produced by these drugs are usually of an urticarial appearance, but they may be of scarlatiniform nature. The following conclusions were presented:

1. Unprotected persons who have suffered injury or undergone operation are much more liable to scarlet fever than healthy individuals. This probably holds good with reference to other infectious diseases.

2. When an epidemic tendency to these symptoms prevails after injuries and operations, it may be concluded that true scarlet fever is present.

3. Septicæmia is occasionally accompanied with a scarlatiniform eruption.

4. Medicinal eruptions, especially from cinchona alkaloids, may follow accidents and injuries.

DISCUSSION.

Dr. P. A. MORROW, of New York: The speaker has not mentioned the rash which often follows the use of antipyrine, which frequently simulates scarlatina, although it is usually of a more measly character. Again, carbolic acid and iodoform dressings will often produce rashes presenting the objective appearances of scarlet fever. There is another eruption known as the "doctor's rash," which appears upon the persons of sensitive individuals when stripped for examination. I have seen this in several cases, in one of which it was very marked.

Dr. L. N. DENSLOW, of St. Paul: I recall the case of a young woman who stated that a scarlatinous eruption always appeared upon her body on exposure to sunlight. In order to test the matter, she was directed to come to the hospital closely veiled and gloved. She was then placed in a dark room and one glove removed. A ray of sunlight was then allowed to fall upon the hand, and at once a strip of erythema appeared. The same occurred on the face when it was exposed.

Dr. I. E. ATKINSON, of Baltimore: While I have seen the rashes mentioned by Dr. Morrow, I did not consider them in my paper, because I was specially interested in those scarlatiniform eruptions following traumatism, and I referred to medicinal eruptions only incidentally.

Adjourned.

(To be continued.)

BAD EFFECTS OF DRESSINGS OF MERCURIC CHLORIDE.—At the Pennsylvania Hospital, two resident-surgeons have been absent on sick-leave, on account of the effects of absorption of the drug in their daily handling of corrosive-sublimate dressings.

OBSTETRICAL SOCIETY OF PHILADELPHIA.

THURSDAY, JUNE 3, 1886.

The President, Dr. B. F. BAER, in the chair.

DR. R. P. HARRIS read for Dr. HOWARD H. KELLY a paper entitled

GONORRHŒAL TUBO-OVARIAN ABSCESS—RIGHT SIDE—LAPAROTOMY—REMOVAL OF FALLOPIAN TUBE AND OVARY—RECOVERY.

In this case the disease of the woman could be directly traced to gonorrhœal infection on the part of the husband, although she had never, to her knowledge, had any uterine discharge other than blood, and had always been regular in her menses during the three years of her married life.

At fourteen Mrs. H. commenced to menstruate; at seventeen she weighed one hundred and thirty-five pounds, although of medium stature, after which she failed somewhat in health from an abscess of a finger, and when married at twenty was quite spare, as was also her husband. Both she and her husband are of German blood. The husband has since reached a maximum of one hundred and sixty-seven pounds. Three years before marriage Mr. H. contracted a gonorrhœa, of which he thought himself cured in three weeks. At the time of his wedding, however, he was suffering from orchitis, which he attributed to a strain, and which lasted for some time. The sickness of his wife commenced with her first menstrual epoch, two weeks after marriage, at which time she had excessive abdominal pains, fever, vomiting, and constipation, and was two weeks in bed; since which time she has had repeated attacks of the same kind.

She came under the care of Dr. Kelly on March 31, 1886, after having been under treatment for a supposed uterine fibroid during five months. After a month's preparation by enemata, vaginal douches, and tonics, it was determined to operate upon her for the removal of a tumor located between the right side of the uterus and the pelvis, and evidently firmly attached in its seat. This tumor had an elastic feel; had greatly affected the health of the patient by the production of menstrual prolongation and excess, and was evidently giving rise to symptoms of septicæmia.

The tumor was removed May 5, 1886, and in separating it from its bed a small cyst containing fetid pus was ruptured. This necessitated irrigation and cleaning of the viscera with hot carbolized water, to avoid septic peritonitis. The pulse rose to 160 the next day, but fell in four days to 76, with a temperature of 98.8°. When examined after removal, the tumor, which was about two and one-half inches in diameter, was found to

consist of an ovary and dilated Fallopian tube, forming a common cavity filled with from two to three ounces of thin, greenish, highly fetid pus.

A drainage-tube was used for four days; the sutures were removed in a week. The patient made a good recovery.

OVARIAN TUMOR.

Dr. T. M. DRYSDALE exhibited the specimen, and remarked: Five weeks ago I removed an ovarian tumor, which, apart from the interest which attaches to each case of this kind, was personally important to me from the fact that it completed my one-hundred-and-fiftieth ovariotomy. Twenty-five years since—April 23, 1861—I performed my first operation of this kind. At that time, as you are aware, the procedure was not in such favor in the profession as it now is, and the operators were few: in fact, I believe I was the first after the late Dr. Washington L. Atlee who operated in this city.

My success has been encouraging. In each series of fifty the mortality has grown less, and the results more and more satisfactory; but, as I expect to present a report of the whole number of cases to you in a short time, I will not now anticipate what will then be stated in regard to these results, further than to say that of the one hundred and fifty cases I have lost twenty.

This tumor was removed from an unmarried lady, 20 years of age, who first consulted me in February for an abdominal enlargement. She was extremely thin and delicate-looking, but said she had enjoyed good health until attacked by the present disease; since then she had emaciated rapidly, her general health had failed, her stomach had become irritable, and her appetite deficient. She had an unnaturally red tongue, and a feeble pulse, which varied from 110 to 140 beats in a minute.

She first menstruated when sixteen years of age, with great pain and excessive flow. Since then she had always suffered agonizing pain during menstruation, but had been regular until within the last six months; during this time she changed every two weeks, flowing for two or three days. For the last month she had a thin, sanguineous discharge every week.

She first noticed enlargement about eighteen months before I saw her. The whole abdomen swelled as if distended with wind, for which it was mistaken, her physicians treating her for a long time for dyspepsia. The increase in size had been very rapid in the last six months. On examination, the abdomen was found to measure thirty-seven inches around its greatest circumference, and was distended by a tumor of irregular shape and consistence. There was dulness on percussion everywhere except in the epigastric region and over the right flank. No fluctuation could be detected except over a small portion in the left side, about the level of the umbilicus, which was evidently cystic. A hard mass could be felt just below this, which appeared like an independent growth. On vaginal examination the cervix uteri was found to be small and flattened against the pubic bone by a hard tumor which nearly filled the pelvis. This mass was found to be continuous with that which was felt to the left of the umbilicus. It was impossible to pass a uterine sound.

I diagnosticated a multilocular ovarian tumor. Assisted by my son, Drs. W. S. Stewart, John S. Stewart, and G. G. Chamberlain, of Middletown, Delaware, I operated April 28. On opening the abdomen, the front of the tumor was seen to be covered by the right broad ligament, which was spread out to a great size and firmly adherent to it. The uterus was turned completely on its axis and fixed by adhesions to the left side of the growth. A large trocar was introduced, but no fluid could be obtained until a cyst was reached high up on the left side. The remainder of the mass was composed of minute cysts and a nearly solid portion, which was that felt in the pelvis and left side before the operation. An incision was made in the wall of the tumor, and, introducing the hand, the interior was broken up as much as possible; yet it was difficult to reduce its size, and I was compelled to enlarge the abdominal incision to about eight inches in length before I could get the tumor through it. The adhesions to the broad ligament and uterus were then detached, as well as some omental adhesions; others to the wall of the right side of the pelvis still held firmly. These were finally broken down, and the tumor, which proved to be of the right ovary, withdrawn. The pedicle, which was very thick and vascular, was secured by ligatures. From the surface of the adhesions there was an active and persistent bleeding, which gave considerable trouble; but this was controlled without the use of ligatures, except two to vessels deep in the pelvis. After thoroughly cleansing the cavity of the abdomen and pelvis, the wound was closed with wire sutures; a compress of absorbent cotton and a flannel bandage completed the dressing. I will not weary you with the details of her progress towards recovery. The only unpleasant symptoms she had were vomiting and violent colicky pains, which lasted at intervals for two days. Her highest temperature in the axillæ was 101¼°. Her pulse varied from 100 to 128. She has entirely recovered, and is daily gaining strength.

W. H. H. GITHENS,
Secretary.

TEREBENE given in large doses too frequently repeated has caused nephralgia, congestion of the kidneys, and scanty albuminous urine.

PHILADELPHIA CLINICAL SOCIETY.

A STATED meeting was held April 23, 1886, the President, Dr. John B. Roberts, in the chair.

Dr. Edward R. Stone reported a case of

EXTRAVASATION OF URINE FOLLOWING REPEATED ASPIRATION OF THE BLADDER.

More than three years ago I was called to J. W., æt. 67, who was suffering with retention of urine. He gave the following history. He had always been very healthy until he began to suffer with difficulty in passing water. This had lasted for some time, and was attributed by him to working in wet places, his duties as engineer at the waterworks often requiring him to stand in water and expose himself to taking cold. He had never before had total retention, but the urine often came drop by drop and was voided with great difficulty. Upon examination by the rectum the prostate was found decidedly enlarged. After patient efforts with various catheters, the bladder was reached by the manœuvre of passing a flexible instrument with the stylet to the seat of obstruction; then by slightly withdrawing the stylet the point of the catheter was made to mount over the enlarged third lobe. The patient was instructed in the use of the catheter; and copaiba was found of benefit in relieving catarrh of the bladder, which was aggravating his complaint. From time to time it was necessary to give him assistance when he failed to catheterize himself. Efforts to reach the bladder were always successful until the night of September 17, 1885, when he was found suffering again with retention. He had already tried the catheter, but unsuccessfully, and had injured the urethra by using an instrument which, being partially broken, had allowed the wire to protrude. Careful and repeated attempts were made during the night to reach the bladder. These failing, Dr. W. W. Keen was called in consultation. It was then decided to aspirate the bladder. This was done with a medium-sized instrument, and about one pint of urine withdrawn. By night the re-accumulation was distressing the patient again, and the aspiration was repeated at 7 P.M., and again at 8.10 A.M. next day. Urine withdrawn amounted to rather more than one pint for the two operations, was clear, but rather dark in color. The first puncture was in the middle line, a short distance above the pubes, and the second and third were close to the first. A circle with a radius of one-fourth inch would have included them all.

September 18 (day after first aspiration), at 4 P.M., I was informed that the patient felt better, as some urine was passing. Examination showed that no urine was escaping from the urethra, but it was welling up drop by drop from two of the three punctures, having displaced the adhesive plaster covering them. The bladder could be felt to extend almost to the umbilicus. The aspirator was used again, and, although the puncture was made in the same neighborhood as before and the trocar appeared to enter the organ, no fluid could be withdrawn except a small amount of bloody serum.

Dr. Keen was called again, and the patient was given ether preparatory to the operation of cystotomy. Under the influence of the anæsthetic, however, Dr. Keen succeeded in passing a silver catheter with prostatic curve, and more than one pint of urine escaped. The bladder was thoroughly washed with warm water and the catheter secured in place. Above the pubes a free incision was made through the skin and subcutaneous fat.

The patient did well until the third day, when symptoms of sloughing of the deep cellular tissue became prominent. An offensive discharge began from the wound, and the deep tissues could be seen to be dead and sloughing. At the same time there was moderate fever. The catheter was left *in situ* for four days, and the bladder was frequently washed (three times daily) with a warm solution of borax. After the removal of the catheter there was no further trouble in introducing it, which was done four times in the twenty-four hours, and the bladder washed as before. The sloughing of the deep connective tissue became quite extensive, extending beneath the muscles on both sides almost to the iliac crest, and for a considerable distance above the incision. The sloughing tissue was drawn out and removed as fast as it became loosened, and carbolic acid solution was injected through a soft catheter passed in various directions under the undermined structures. Patient's strength failed rapidly under fever and diarrhœa due to septicæmia, but he rallied as the abscess became clear of sloughing tissue and began to heal; but he sank and died of exhaustion, October 11, twenty-four days after the extravasation of urine occurred. The wound had almost healed, and, although he had not been able to void his urine, the bladder remained free from catarrhal complication. No post-mortem.

Without doubt the patient's death was at least indirectly due to the escape of urine through the punctures in the bladder infiltrating and causing to slough the deep connective tissue. Is it good practice to trust to repeated aspirations? Our case demonstrated, I think, that even the small puncture of the needle may be stretched open, as the bladder again distends, to a sufficient extent to permit urine to escape into the surrounding tissues.

Again, it should not be decided that a catheter cannot be passed until the attempt has been made under an anæsthetic. In this case the instrument was passed after the patient was under the full influence of ether, when it

could not be made to enter the bladder without the anæsthetic. Much organic obstruction plus even a slight amount of reflex spasm may baffle the surgeon, when, with the latter condition annulled by anæsthesia, success may crown his efforts. In this connection, however, it must be borne in mind that the urethra had had complete rest from all manipulation for more than thirty-six hours before Dr. Keen succeeded with the catheter.

Dr. Stone also reported a case of

SPONTANEOUS CURE OF EMPYEMA.

G. H., boy, æt. 2 years and 9 months; has always been healthy, except a convulsion at seven months, due to indigestion; had a slight cold for a few days until March 1, 1885, when he was feverish and had a severe spasm. In the afternoon fever, cough, and restlessness continued, but it was not until March 3 that a diagnosis of pleurisy could be made, his restlessness and excitement preventing an examination of the chest. On that day the respirations were rapid and evidently suppressed, and he complained constantly of pain in his belly. A friction-sound could be plainly heard over the lower lobe of the right lung, in the axillary line. March 9, the right chest was distended to a point about midway between the nipple and the clavicle, and to a corresponding point behind; after which the effusion gradually declined with the cessation of the fever and general improvement in the child's condition.

Early in May he was taken to the country, at which time his condition was fair, although he still coughed and the lower part of the chest remained dull, with impaired respiratory movement. I saw no more of him until November 23, 1885. He was then weak and thin; anorexia complete; daily fever, night-sweats, with painful cough when recumbent; the right chest was largely distended, intercostal spaces obliterated; flatness except in the extreme upper part of the chest. An operation was urged; but the parents hesitated and wanted time to consider it.

On November 25 I was sent for, and found that a large swelling had formed just below the right nipple, measuring about four inches in its greater diameter. This fluctuated and became tense when the child cried, and evidently marked the escape of pus from the pleural cavity.

Dr. Heilman saw the case with me, and, although there were two points where the abscess was about to break, we agreed to withdraw the fluid in the usual way with the aspirator, in order, if possible, to prevent the escape of pus in front. The chest was punctured in the sixth interspace, in a line with the posterior border of the axilla, and a little less than one pint of brownish, inodorous pus withdrawn. The abscess-cavity in front became flaccid and empty, and pressure was made over it with a compress and adhesive plaster. The patient's general condition was much improved by the operation, and all went well until the fifth day, when the skin over the abscess gave way in two points and the child's clothing was found drenched with the discharge. On taking off the dressings, two round openings, about one-sixth inch in diameter, were found, through which the air was whistling back and forth with every respiration. The openings were covered with valves of adhesive plaster, as I feared the draught through them would suck in some particles of threads of the oakum which was applied to absorb the pus. No other application than this was made. The discharge of pus continued very free for several days, then gradually became less profuse and more watery, and after one month entirely ceased. It remained throughout perfectly sweet and inodorous. The patient's condition rapidly improved, and he is now entirely well, except that there is some dulness posteriorly, with rather feeble respiration in the lower lobe. This case is of importance as showing what might be called the natural history of empyema; it is remarkable as demonstrating that the air is not always charged with deadly germs which must be destroyed by antiseptic solutions. The ordinary air had free access to the pleural cavity of this boy for many days, without causing the least disturbance. What a brilliant triumph this would have been for antiseptic surgery if I had decided to enlarge the sinus and wash out the pleural cavity with antiseptic solution, instead of adopting a purely expectant plan of treatment!

Dr. Stone then reported a case of

RECOVERY FROM SEVERE DIPHTHERIA WITH NUMEROUS COMPLICATIONS.

W. H., æt. 4 years, healthy boy, but slender and not very robust. His mother's family is consumptive, and she has a tendency to phthisis with implication of the left apex.

On December 7, 1885, he was noticed to be dull and feverish. On the 8th, moderate fever and languor, throat red, with false membrane on both tonsils. On December 10 the deposits had extended until they completely covered fauces and pharynx; fever moderate, pulse 120 and feeble; is dull and apathetic.

December 12. No change in throat; serous discharge issuing from the nostrils, which were observed to be lined with diphtheritic membrane as far as could be seen; respiration entirely through the mouth. The child's strength rapidly failed until December 15. He lies quiet in a somnolent state and is with difficulty aroused, and refuses to attempt to swallow anything; pulse 140 per minute and feeble; temperature (A.M.) 102°. He remained in this desperate condition for about forty-eight hours, when he slowly revived. General condition better, but the nose and

throat still thickly covered with deposit. He attempts to drink a little water.

By December 20 there was decided improvement, the throat clearing and one nostril becoming pervious; is taking milk and stimulants freely; fever less; pulse 120 and stronger.

December 23. Fresh access of fever in the evening, and violent excitement and restlessness; he rolls his head continually and moans as if in pain; again refuses to swallow anything; fever and pain continued with evening exacerbations, and on December 25 a discharge was discovered issuing from the left ear, and the mother asserted that he was quite deaf.

December 26. Both ears discharging, and patient quieter; moderate evening fever; both nostrils seem quite clear; he can with difficulty be persuaded to take liquids,—much of which, however, returns through the nose. The throat is free of deposit; but there is evident paralysis of the palate-muscles.

After the above note he gradually improved; but from January 2 to 8 there was great irregularity of the heart's action. Examination of the ears from time to time showed a succession of furuncles deep in the meatus, which entirely concealed the membrana tympani.

February 1. He began to cough, but examination was negative in results; he has fever in the evening and night, with sweating towards morning.

February 3. Cough very troublesome at night, and painful. Patient evidently suppresses cough and complains when handled, but auscultation only reveals a few coarse râles; respirations 40 per minute, pulse 110; he is losing his appetite, and sleeps badly; fever remittent (99° to 100°, A.M.; 102° to 103°, P.M.).

February 5. Signs of effusion in the right pleura; no friction-sound detected.

February 12. Effusion reached its maximum; dulness to a point midway between nipple and clavicle in upright position, subsiding to much lower point when recumbent. After this the effusion rapidly disappeared, and was associated with a severe diarrhœa and free evacuation of urine, his general symptoms improving *pari passu*.

February 19. Effusion about disappeared, some dulness, however, remaining at the base of the lung, with feeble respiratory sounds; the ears continued to discharge in a lessened degree, and hearing improved.

About the middle of March he began to be able to stand alone, but it was several days longer before he was able to walk. About the same time he commenced again to use simple words, the power of speech having been in abeyance ever since he became very ill. Emaciation was extreme; I have never seen a person more wasted; but flesh was resumed rapidly during convalescence. Dr. Heilman examined the ears with me, and found evidence of middle-ear disease with perforation.

Condition April 17, 1886: looks almost as well as before illness, but is somewhat thinner; ears have ceased to discharge, and there is very little impairment of hearing; he has no cough, but his breathing is rather rapid, especially after exertion; the right chest is somewhat impaired in movement, and there is slight dulness on the right posteriorly, with feeble respiratory murmur; respiration on left exaggerated; his appetite is not so good as during the early part of convalescence, but he drinks milk freely; is bright and playful.

The treatment in this case may be summarized as follows: tinct. ferri chlor. and hydrarg. chlor. corrosiv. by the mouth, quinine by suppository, the almost constant employment of a spray from a steam-atomizer of a solution of carbolic acid in lime-water and the injection of the same frequently into the nostrils, followed by insufflation of sulphur; whiskey (maximum dose, f℥iij in twenty-four hours) with milk; insufflation of boric acid; and, later, iodoform for the otorrhœa. Tincture of digitalis was given freely when the heart failed, and digitalis and ammonia (with iodine externally) were used to combat the pleurisy.

Too much credit cannot be given to the mother's devoted and unremitting attention. Her efforts to save her only child never faltered; and while he lay in a semi-comatose state she patiently administered, drop by drop from a medicine-dropper, whiskey and milk, which trickling into the throat would be unconsciously swallowed. I believe that these minimum doses of nourishment were sufficient to tide him over a critical period, during which he would have succumbed under less assiduous nursing.

DISCUSSION.

In the discussion which followed the reading of Dr. Stone's cases, Dr. Bruen spoke of a case in which an over-distended gall-bladder was aspirated with a very fine needle. Peritonitis set in, which terminated fatally. He felt as though he would like to be sure that the gall-bladder and peritoneum were adherent before using the aspirator hereafter.

He mentioned two cases of empyema in adults in which the aspirator was used, pus withdrawn, and after a few months there were evidences of thickened pleuræ. He has resorted to resection of the ribs in a few cases of empyema, and spoke of the necessity of preserving enough of the periosteum to cover the ends of the ribs; otherwise necrosis is apt to occur.

Dr. Charles H. Thomas said it is a question in his mind whether "it is best to *repeat* aspiration of the bladder: it may be done *once* in order to gain a few hours' time." He mentioned a case of ovarian tumor in which the aspirator was used; only a small quantity of fluid was

drawn off; in a short time there was a rigor, and death occurred in three days; the autopsy revealed the evidences of peritonitis. Exploratory abdominal incisions should be considered, rather than aspirating.

Dr. Henry Hartshorne spoke of a case of empyema in the medical ward of the Pennsylvania Hospital in the year 1840, in which spontaneous rupture occurred. The case terminated in recovery.

Dr. Stone, in closing the discussion, said that in children it was rarely necessary to resect the ribs for empyema; that they often recovered after simple withdrawal of the fluid.

Dr. John B. Roberts then gave a verbal report of a case in which

IMMINENT DEATH IN ACUTE PNEUMONIA WAS AVERTED BY PHLEBOTOMY.

The patient was a man, æt. 55. After exposure to cold, pneumonia developed in the lower lobe of the left lung. One evening he was in great distress; respirations numbering 45 per minute; on percussion, dulness and flatness were found over both lungs; on auscultation, numerous coarse and some fine râles were heard on both sides; lips cyanosed; death imminent. Dry cups were used over the chest posteriorly, and phlebotomy to the extent of twelve ounces practised. The respirations immediately fell to 35 per minute; the patient became comparatively comfortable; slept some during the night, and was much better the next morning. Convalescence went on uninterruptedly from that time.

Dr. Henry Hartshorne remarked upon the contrast between the now prevailing treatment of pneumonia and other acute inflammatory affections and that of forty years ago. Results do not show that the change has been to the advantage of medical practice. Formerly, even under hospital treatment, death from pneumonia was not frequent; in private practice it was rare.

Dr. L. P. Gebhard, near the end of half a century's large experience, said that he had never lost a case of uncomplicated pneumonia. Now we hear very different accounts. Men in the vigor of life not infrequently die of the disease after a few days of illness.

Dr. Hartshorne has reached the conviction that a radical mistake is prevalent in regard to the practical indications in simple acute pneumonia. What have we therein as prominent pathological conditions?

1. Obstruction to the circulation at the seat of local inflammation.

2. Resulting general increase of vascular tension.

3. Arrest or considerable diminution of the secretions of the skin, kidneys, and bowels.

In all these conditions there is no indication for alcohol, none for quinine, none for opium. The old-time remedy for the abnormal vascular tension of the first stage was the abstraction of a moderate amount of blood, according to the previous vigor of the patient, by venesection, cupping, or leeching. Having been brought up under this régime, Dr. Hartshorne can give personal testimony to its safety and frequent advantage. It is astonishing that in these days of daring surgery, of ovariotomy, and laparotomy, for various occasions, physicians should be so much afraid of taking from a patient a few ounces of blood.

An adjuvant for such a measure of relief in the early stage of pneumonia, or substitute for it in doubtful cases, is the use of saline purgatives and diaphoretics. These also appear to be in recent practice very often, perhaps generally, neglected, Dr. Hartshorne believes, to a great disadvantage.

Frankly speaking, under the following plan of practice six out of ten cases of acute pneumonia in persons of previously good health, between twenty and fifty years of age, may be reasonably expected to die,—viz., treating them from the start with twenty grains of quinine daily, a tablespoonful of whiskey every two or three hours, and a quarter of a grain of sulphate of morphia every six or eight hours. If any patients recover under such treatment, it is an escape probably due to the use of large hot poultices kept applied to the chest; an excellent application.

Another method of treatment Dr. Hartshorne has had ample experimental reason for believing will be followed by recovery in at least eight out of ten cases of simple acute pneumonia in persons not over sixty years of age, of previously good health,—viz., the abstraction, on the first, second, or not later than the third day, of a few ounces of blood from the arm in the stronger patients, by cups or leeches in those of less previous vigor of system; about the same time, a decidedly purgative dose of some mild saline medicine; afterwards, every two or three hours, a saline diaphoretic, citrate, acetate, or nitrate of potassium, or acetate of ammonium; in the most violent cases, in patients of average constitution, tartar emetic during the first three, four, or five days,—not more than one-sixteenth to one-twelfth of a grain every three or four hours, not allowed to cause gastric distress; a warm poultice also being kept applied and renewed over the whole anterior part of the chest until the worst is over.

Should this practice be just now out of fashion, it may be very earnestly said that it is better to be old-fashioned than to lose a considerable number of patients dying of a malady like pneumonia, which *ought not to be mortal.*

MARY WILLITS, M.D.,
Reporting Secretary.

RHUS-POISONING.—Much discussion has been given lately to the treatment of rhus-poisoning, but we know of no better dressing than a solution of baking-powder, followed by lard beaten up with lime-water.

REVIEWS AND BOOK NOTICES.

A Treatise on Therapeutics: comprising Materia Medica and Toxicology, with Especial Reference to the Application of the Physiological Action of Drugs to Clinical Medicine. By H. C. Wood, M.D., LL.D. Sixth Edition, Revised and Enlarged. Philadelphia, J. B. Lippincott Company, 1886.

The author has taken advantage of the opportunity for revision (made necessary by the changes introduced into the last edition of the Pharmacopœia) to make some important additions. An article upon Cocaine has been introduced, the chapter upon Disinfectants entirely rewritten, and he has spared no effort to have the work fully and correctly represent the best therapeutic deductions of the day.

The former main divisions are preserved of Drugs and Forces (under which the therapeutics of Caloric and Electricity are considered), and an appendix contains instructions upon Prescription-Writing and various tables. The work represents a large amount of painstaking research by the author, and shows his complete mastery of the subject. Its adoption as a text-book by a number of our medical colleges is of itself warrant sufficient for its value to students, which is further demonstrated by its many evidences of undiminished vitality in its sixth edition.

A Hand-Book of the Diseases of the Eye and their Treatment. By Henry R. Swanzy, A.M., M.B., F.R.C.S.I., etc. With Illustrations. New York, D. Appleton & Co., 1884.

This is a clearly-written manual which has been prepared especially for the use of students attending the Ophthalmic Hospital, but is also serviceable as a book of reference for those engaged in the clinical study of eye-disease. Omitting the anatomy of the organ of vision, the subject is introduced by a study of elementary optics, which leads at once to a consideration of errors of refraction and accommodation, and the ophthalmoscope. The diseases of the various eye-structures are studied systematically, and judicious observations made with regard to treatment. In the paragraphs devoted to astigmatism the subject is despatched rather briefly, and the impression might be left that astigmatism occurs only in the vertical and horizontal meridians. On the whole, the work is carefully written, and is evidently that of an experienced surgeon. Holmgren's color-test and Snellen's "Sunrise" are appended to the work.

An Aid to Materia Medica. By Robert H. Dawbarn, M.D. New York, J. H. Vail & Co., 1884. 12mo, pp. 86.

This is an interleaved compendium containing the officinal drugs and their preparations, with doses. Prescription-writing by the metric method is taught by an easy plan in the appendix.

NEW REMEDIES AND CLINICAL NOTES.

Phosphor-Necrosis.—Dr. W. C. Jacobs, having a connection with one of the largest match-factories in the United States (at Akron), has had unusually favorable opportunities of observing this disease. He presented a paper upon this subject at the last meeting of the Ohio Medical Society, in which he described the process of match-making in detail. About one-seventieth of a grain of phosphorus is contained in each match-head. It is particularly in the dipping- and packing-rooms that the danger of acquiring phosphor-necrosis is greatest. Here the matches are handled more, and in damp weather fumes are given off. The effects of phosphorus are at first local. In his ten cases all started from unsound teeth. Gums kept from the teeth by tartar is also a cause. It is generally thought that the patient in order to acquire the malady must have been exposed for a long time to the fumes of the phosphorus, but this is not necessarily the case. The essayist knew one girl who was exposed for only two years. The physician rarely sees it in the initial stage. Generally the patient comes a few days after having a painful carious tooth extracted, and wishes to know why he still has pain.

Treatment: tincture of myrrh well diluted is a good mouth-wash. Deep incisions had not been so successful in the essayist's hands. He is a firm believer in the early operation. As to prevention: first, he would allow no one to work in the dipping and packing department who has not sound teeth; second, good ventilation is essential; third, operators must not be allowed to eat dinner in their work-rooms, and should be required to keep their hands clean; fourth, for convenience, keep a solution of the alkaline carbonates as a mouth-wash.

Dangers of Carbolic-Acid Dressings.—Dr. Weaver, of Dayton, reported a case at the Ohio State Medical Society where a young woman came to him with her finger perfectly dead, caused by an application of carbolic acid. It had been applied accidentally, and immediately wiped off. Gangrene set in in two or three days. Dr. Underwood reported the case of a girl, æt. 10, who burnt her finger. Her mother, having heard that carbolic acid was good for burns, applied it. The finger remained wrapped up till morning, when it was found dead, the doctor called, and the finger amputated.

Sloughing following Carbolic-Acid Injection into a Hydrocele.—Dr. William

C. Wile reports a case of disastrous results following the injection of pure carbolic acid for the radical cure of hydrocele. A farmer went to a physician's office for treatment for a hydrocele. Carbolic acid was injected into the sac, and in the course of a few days there were symptoms of carbolic-acid poisoning and intense inflammation and sloughing of the scrotum. Free incisions, hot applications, and stimulants were successful in averting the threatened fatal results, but convalescence was long and tedious.

MISCELLANY.

THE LEGAL RIGHT OF CHINESE TO WASH CLOTHING IN CALIFORNIA.—The Chinese must be allowed to carry on the laundry business in the California towns, is the purport of a recent decision of the United States Circuit Court. The officials in one of the large cities of that State, with the intent to drive the Chinese away, but on alleged grounds of health and public policy, passed an ordinance prescribing the limits within which the laundry business could be carried on. It turned out that these limits comprised a very unhealthful part of the city, and the better portions were excluded from any intrusion on the part of the Celestials. This ordinance was thought unjust and illegal, and the question was taken into the United States courts, which have now held that no discrimination like that intended can be imposed.

The court holds that cleanliness is necessary to civilization, necessary to the health, comfort, and happiness of a civilized people. Without it, every man, woman, and child would individually himself or herself become a nuisance to his or her neighbor. The right to labor in this or any other honest, necessary, and in itself harmless calling where it can be most conveniently, advantageously, and profitably carried on is one of the highest privileges and immunities secured by the Constitution to every American citizen, and to every person residing within its protection.

The police power is invoked to sustain this ordinance, but the police power extends only to the regulation of the necessary pursuits of man, so that they shall not become in their mode of exercise unhealthy, noisome, dangerous, or otherwise detrimental or injurious to the common interests of the community. It does not extend to the destruction or driving to inconvenient and unprofitable localities of necessary or useful occupations carried on in such a manner as to be harmless.

THE KENTUCKY STATE MEDICAL SOCIETY elected the following officers for the ensuing year: President, Dr. W. H. Wathen, Louisville; Senior Vice-President, Dr. J. H. Harwood, Shelbyville; Junior Vice-President, Dr. J. H. McKinley, Winchester; Permanent Secretary, Dr. J. Steel Bailey, Stanford; Assistant Secretary, Dr. F. C. Simpson, Bardstown; Treasurer, Dr. Edward Alcorn, Hustonville; Chairman of Committee of Arrangements, Dr. J. G. Brooks, Paducah; Board of Censors, Dr. D. S. Reynolds, Louisville, Chairman; Dr. A. W. Willis, Winchester; Dr. A. Sargent, Hopkinsville; Dr. J. H. Loscher, Henderson; Dr. W. E. Poynter, Midway; Dr. J. W. Harwood, Shelbyville. The next place of meeting, Paducah, the third Wednesday in June.

BACILLUS OF DYSENTERY.—Two Italian physicians (in the *Rivista Internazionale di Medicina e Chirurgia*, No. 12) allege that they have discovered that dysentery is caused by the presence of a bacillus not yet described. This parasite they have invariably detected in the fæces of dead patients who have succumbed to dysentery, in the air of hospital wards where the patients were congregated, and in the water of two wells which had been exclusively used for these patients.

A NUTRIENT TONIC.—The combination of calisaya and aromatics with albuminoids obtained from beef, as found in the Liquid Beef Tonic of Colden, has been found useful especially in chronic diseases accompanied by debility, weakness, loss of appetite, and indigestion, and in incipient phthisis.

A PERMANENT EMULSION OF COD-LIVER OIL.—William F. Kidder & Co., of New York, have succeeded in producing an emulsion of cod-liver oil which under all conditions of temperature will retain its smooth and cream-like consistency without any separation of the oil. After years of experimentation with their hydrated oil, or hydroleine, they have finally succeeded in making a perfect and permanent emulsion, which they claim will keep in any climate for any length of time without the least separation. As now offered to the profession, the medicinal qualities are unaltered, with the exception of a slight change in its consistency (being somewhat thicker), and the preparation possesses the same composition and therapeutic value as before.

A PERFECTED PESSARY AND ABDOMINAL SUPPORTER.—Dr. Ernest I. Hofmann, of New York, is the inventor and manufacturer of a Perfect Anatomical Pessary, which is made of soft rubber, and which is distinguished from all others by the form, as it is accurately shaped to the natural dimensions of the upper portion of the vagina. For the treatment of prolapsus and ulceration occurring in married women especially it has given complete satisfaction. The value of a good abdominal supporter is scarcely less than that of a good pessary. The Perfected Adjustable Abdominal Supporter of Dr. Hofmann we regard as a great improvement over the old form.

NOTES AND QUERIES.

THE Conference of the various Committees appointed by Scientific bodies, and Eminent Alienists, to agree upon a uniform classification of Mental Diseases in order to secure the best basis of International Statistics of the Insane, in co-operation with the International Committee appointed at the Antwerp Congress, held by the Belgian Society of Mental Medicine last autumn, will be held at Saratoga, New York, on September 8, 1886, at ten o'clock A.M. Dr. Pliny Earle has been invited to preside.

EDITOR MEDICAL TIMES:

DEAR DOCTOR,—I find in the *Medical Times* of August 21, 1886, under the head of "New Remedies and Clinical Notes," a paper read before the Dakota Medical Society on the treatment of diphtheria by Dr. M. Ware, in which the doctor gives as the new treatment the thorough washing of the throat with a solution of salt and water, and the use of iron, brandy, etc.

If Dr. Ware will examine the *Cincinnati Medical and Surgical News* (new series, vol. ii. No. 4, p. 104) for April, 1861, he will find a report of four hundred and eighty-nine cases of diphtheria treated by the writer during the winter of 1860 and 1861. Four hundred and eighty-eight of these cases were treated by the free and thorough use of the chloride of sodium as a gargle and wash, and also the internal use of quinine, iron, etc.

The writer has for over twenty-five years used salt alone as a wash; and, combined with chlorate of potassa and bicarbonate of soda in solution, he has given it in full doses internally every hour or two. Iron, whiskey, brandy, and quinine he always gives freely.

Yours truly,

C. R. EARLEY, M.D.

RIDGWAY, PA., August 30, 1886.

OFFICIAL LIST

OF CHANGES IN THE STATIONS AND DUTIES OF OFFICERS SERVING IN THE MEDICAL DEPARTMENT U.S. ARMY FROM AUGUST 8, 1886, *TO AUGUST* 28, 1886.

LIEUTENANT-COLONEL DAVID L. MAGRUDER.—Promoted to Surgeon with rank of Colonel, July 26, 1886, *vice* Brown, retired.

MAJOR CHARLES T. ALEXANDER.—Promoted to Surgeon with rank of Lieutenant-Colonel, July 26, 1886, *vice* Magruder, promoted.

CAPTAIN HENRY M. CRONKHITE, ASSISTANT-SURGEON.—To be Surgeon with the rank of Major, July 26, 1886, *vice* Alexander, promoted.

FREEMAN V. WALKER, of Georgia.—Appointed Assistant-Surgeon, July 27, 1886, *vice* Cronkhite, promoted.

MAJOR J. C. BAILY, SURGEON.—Granted one month's leave of absence. S. O. 111, Division of the Atlantic, August 17, 1886.

MAJOR A. A. WOODHULL, SURGEON.—Granted leave of absence for fourteen days, to take effect on or about September 1, 1886. S. O. 197, A. G. O., August 25, 1886.

MAJOR E. BENTLEY, SURGEON.—Granted one month's leave of absence, and at its expiration to report for duty as post-surgeon at Little Rock, Arkansas. S. O. 113, Division of the Atlantic, August 18, 1886.

MAJOR W. S. TREMAINE, SURGEON.—Sick-leave further extended six months. S. O. 187, A. G. O., August 13, 1886.

MAJOR M. K. TAYLOR, SURGEON.—Leave extended one month. S. O. 195, A. G. O., August 23, 1886.

CAPTAIN J. V. LAUDERDALE, ASSISTANT-SURGEON.—Granted leave of absence for two months, with permission to apply for one month's extension, when his services can be spared. S. O. 195, A. G. O., August 23, 1886.

CAPTAIN L. Y. LORING, ASSISTANT-SURGEON.—Leave of absence granted him in S. O. 59, August 2, 1886, Division of the Pacific, extended two months, on surgeon's certificate of disability. S. O. 189, A. G. O., August 16, 1886.

CAPTAIN B. D. TAYLOR, ASSISTANT-SURGEON.—When relieved by Surgeon Bentley, to proceed to Jackson Barracks, Louisiana, and report for duty as post-surgeon. S. O. 113, c.s., Division of the Atlantic.

FIRST-LIEUTENANT WILLIAM E. HOPKINS, ASSISTANT-SURGEON.—Assigned to duty as post-surgeon at Angel Island, California. S. O. 61, Division of the Pacific, August 6, 1886.

LIEUTENANT WILLIAM C. BORDEN, ASSISTANT-SURGEON.—Assigned to temporary duty at Fort Bridger, Wyoming Territory, during absence of Assistant-Surgeon Crampton. S. O. 100, Department of the Platte, August 9, 1886.

FIRST-LIEUTENANT CHARLES M. GANDY, ASSISTANT-SURGEON.—On expiration of his present leave of absence, relieved from duty in the Department of the East and assigned to duty in the Department of Texas. S. O. 195, A. G. O., August 23, 1886.

FIRST-LIEUTENANT CHARLES F. MASON, ASSISTANT-SURGEON.—Assigned to duty as post-surgeon at Plattsburg Barracks, New York. S. O. 113, Division of the Atlantic, August 18, 1886.

LIEUTENANT PHIL. G. WALES, ASSISTANT-SURGEON.—Relieved from duty in the Department of the Columbia, and to report in person at headquarters, Division of the Pacific, for further orders. S. O. 62, Division of the Pacific, August 9, 1886.

LIST OF CHANGES IN THE MEDICAL CORPS OF THE U.S. NAVY FROM AUGUST 7, 1886, *TO AUGUST* 28, 1886.

PASSED ASSISTANT-SURGEON CHARLES. D. RUSH.—Detached from the Receiving-Ship "Franklin" and ordered to the U.S.S. "Pinta."

PASSED ASSISTANT-SURGEON W. G. G. WILLSON.—Detached from the U.S.S. "Pinta;" ordered home and wait orders.

DR. E. P. STONE.—Commissioned an Assistant-Surgeon in the Navy, August 5, 1886.

ASSISTANT-SURGEON A. R. WENTWORTH.—Ordered to temporary duty at Navy-Yard, League Island, Pennsylvania.

PASSED ASSISTANT-SURGEON G. C. LIPPINCOTT.—Ordered to Annapolis, Maryland, for temporary duty as a member of the Medical Examining Board.

MEDICAL-INSPECTOR JOHN H. CLARK.—Ordered to special duty, Portsmouth, New Hampshire, and Widow's Island.

MEDICAL-INSPECTOR D. KINDLEBERGER.—Ordered to Hospital, Washington, D.C., October 1, 1886.

MEDICAL-DIRECTOR A. L. GIHON.—Ordered to Hospital, Mare Island, California, October 15, 1886.

MEDICAL-INSPECTOR SOMERSET ROBINSON.—Detached from Hospital, Mare Island, California, October 15, 1886, and wait orders.

MEDICAL-INSPECTOR J. C. SPEAR.—Ordered to Naval Laboratory, New York, September 28, 1886.

MEDICAL-DIRECTOR DELEVAN BLOODGOOD.—Ordered to Hospital, Norfolk, Virginia, September 29, 1886.

MEDICAL-DIRECTOR J. Y. TAYLOR.—Ordered to Naval Laboratory, New York, September 29, 1886.

MEDICAL-DIRECTOR R. C. DEAN.—Detached from Naval Hospital, New York, and wait orders.

SURGEON W. J. SIMON.—Detached from the U.S.S. "Constellation," and special duty at Naval Academy, Annapolis, Maryland.

ASSISTANT-SURGEON C. P. HENRY.—Ordered to Hospital, Philadelphia, Pennsylvania.

PASSED ASSISTANT-SURGEON H. B. FITTS.—Detached from Hospital, Philadelphia, Pennsylvania, and wait orders.

ASSISTANT-SURGEON E. P. STONE.—Ordered to Receiving-Ship "New Hampshire."

OFFICIAL LIST OF CHANGES OF STATIONS AND DUTIES OF MEDICAL OFFICERS OF THE U.S. MARINE HOSPITAL SERVICE FOR THE WEEK ENDING AUGUST 7, 1886.

HUTTON, W. H. H., SURGEON.—To proceed to Key West, Florida, for temporary duty, August 7, 1886.

BEVAN, A. D., ASSISTANT-SURGEON.—Ordered to examination for promotion, August, 1886.

WILLIAMS, L. L., ASSISTANT-SURGEON.—When relieved at Buffalo, New York, to proceed to Mobile, Alabama, for temporary duty, August 2, 1886.